NATIONAL HEALTH INSURANCE
AND THE
MEDICAL PROFESSION

By

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1920
PRUDENTIAL PRESS
NEWARK, N. J.
U. S. A.

PREFACE

The following observations on the Medical Aspects of National Health Insurance under the national insurance system of Great Britain are not intended as a complete presentation of a subject which is of truly enormous proportions. It was clearly realized at the outset of the investigation that the difficulties to be overcome might prove insuperable unless the inquiry was limited to certain well-defined public aspects of a question which of recent years has attracted considerable attention in the United States. It was therefore thought best to present the essential phases as occasion might offer, and the following remarks are a consolidation of papers read before state and local medical societies during the present year.*

National health insurance is fundamentally a problem of practical politics and social expediency. It is not and cannot be a solution, in that it does not honestly aim at the removal of the causes which give rise to illness and social dependence. It is at best a makeshift and at worst a causative factor in the further pauperization of the people.

Once adopted, national health insurance has practically come to stay. In much the same manner as the 43 Elizabeth, or the English Poor Law of 1601, continues to exercise its evil influence upon the people of England at the present time, or more than four hundred years after its adoption, so the unfortunate consequences of national health insurance may continue to blight the social and economic welfare of the British people for generations to come. Those who are victims of the system naturally rise to its defence in the hope that by further legislation urgently required improvements may be brought about. No phase of the subject illustrates this conclusion more forcibly than the medical. Any one making diligent inquiry in England of both panel and non-panel physicians and observing for himself the actual methods of panel practice, particularly in congested industrial districts, must needs be struck with the total inadequacy of a method which affords at best but a minimum of relief not much above, if not actually below the medical support heretofore granted under the poor law.

*In this investigation (made in England during the summer and fall of 1919) I have had the hearty cooperation of so large a number of men and women in public and private life throughout the United Kingdom that, much to my regret, I must of necessity abstain from making a personal acknowledgment of more than a few, but for whose help the objective of a reasonably thorough inquiry into all the facts of National Health Insurance would have been entirely out of the question. I desire to make special acknowledgment of the cooperation extended to me by the late Sir William Osler, Lord Dawson of Penn, Sir Clifford Allbutt, President of the British Medical Association, Sir Arbutnoth Lane, Sir Darcy Powers, Sir George Newman, Chief Medical Officer of the Ministry of Health, Sir Charles Cameroon, Sir John Collie, Sir Thomas Oliver, Sir Ronald Ross, Sir Rickman Godlee, Sir William S. Glyn-Jones, Secretary of the Pharmaceutical Society, Sir John MacAllister, Secretary of the Royal Society of Medicine, Sir David Shakelton, of the Ministry of Labor, Sir John Burn, General Manager of the London Prudential, Sir Walter Fletcher, the Secretary of the Medical Research Committee, Sir Kingsley Wood, M. P., Sir James Leishman, Chairman of the Scottish Insurance Commission, Sir Joseph Glynn, Chairman of the Irish Insurance Commission, Baron Waldorf Astor, the Right Honorable John Burns, the Right Honorable Arthur Henderson, M. P., and many others whose assistance was as generous as it was valuable.

Another conclusion easily susceptible of proof is that national health insurance hopelessly divides the British medical profession, and that panel doctors are again divided into those who exclusively rely upon panel practice and those who carry on a small panel practice in addition to a much more remunerative private practice. There can be no question of doubt that the mediocre physician has had his economic status materially improved. On the other hand, the ambitious physician in panel practice finds himself confronted by a practically hopeless outlook for the future.*

The defence which is made of the British system by those who are a part thereof cannot be accepted as admissible evidence in view of the overwhelming contradictory proof easily derived from the current issues of the *British Medical Journal*, the *Lancet*, the *Medical World*, the *Medical Officer*, and other medical periodicals entitled to respect. Of importance also are the occasional articles on health insurance by the medical correspondent of the *London Times*, and the contributions on the subject in the *Scotsman* of Edinburgh. The activities of the Medico-Political Union are of exceptional interest, in that they clearly foreshadow the reorganization of the British medical profession in conformity to the principles of a trade union. There can be no alternative to this effort but the destruction of the old ideals of medicine as a profession and the new view-point of an ancient and honorable calling conceived primarily as a trade.† The Medico-Political Union has, however, the merit of making a determined fight for the conservation of the economic interests of the medical profession, which as concerning the panel physician is in a fair way of being converted into a salaried public medical service.

Every important contention for which the British Medical Association has made a fight has been lost. It set out originally for an income limitation of £130, but it yielded to £160, and subsequently to £250. It was opposed to a limitation of names on the panel, but it yielded to a minimum of three thousand names, adopted under the new Medical Benefit Regulations. It bitterly opposed restrictions upon the sale or transfer

*The following are a few references to recent discussions of far-reaching reforms in English medical practice, both private and public, emphasizing a new view-point which it would be fatuous to ignore: Letter on the Future Provision of Medical Services, by Alexander Blackhall Morrison, *British Medical Journal*, June 12, 1920; Lord Dawson on the Consultative Council's report on the Future Provision of Medical Service, *British Medical Journal*, June 12, 1920; editorial on the Organisation of Medical Service, *Lancet*, July 24, 1920; Annual Report of the Federation of Medical and Allied Societies, *Lancet*, July 31, 1920; From the Cradle to the Grave, editorial, *Lancet*, July 31, 1920; Some Defects in Medical Administration and Their Remedies, by Sir James Mackenzie, *Lancet*, August 7, 1920; on the Certification of Insured Persons in Ireland, *Lancet*, August 7, 1920; Provision of Expert Medical and Surgical Treatment, by Dr. A. H. Bygott, *Lancet*, August 14, 1920; Inquiry into a Practitioner's Conduct, *British Medical Journal*, August 21, 1920; letter on Collective Bargaining and Colliery Practice, *British Medical Journal*, August 21, 1920; Some Thoughts on the National Health Insurance Act and the Panel, by Dr. James Hamilton, *Medical Press and Circular*, August 25, 1920; The Medical Service Scheme of Messrs. Thomas de la Rue and Company, *British Medical Journal*, August 28, 1920; The Future of Colliery Practice, by Dr. Alfred Cox, *British Medical Journal*, September 11, 1920; Summary of the Discussion at Cambridge on the Future of Medical Practice, by Dr. Peter MacDonald, *British Medical Journal*, September 18, 1920; A Physical Therapeutic Centre, by Dr. T. Lister Lewellyn, *British Medical Journal*, September 18, 1920; on the Capital Value of Medical Practice: The Dartford Scheme, *British Medical Journal*, September 25, 1920; The Profession in a Socialist Commonwealth, *British Medical Journal*, September 25, 1920; New Ideals of Healing, article by the medical correspondent, *London Times*, October 5, 1920.

†Among the objects of the Medico-Political Union enumerated in the book of rules is the following: "The object of the Union shall be to impose restrictive conditions on the conduct of the *trade* or business of the medical practitioner."

of panel practices, but nevertheless such a rule has gone into effect and is now a law of the land.

It is opposing consulting clinics, but it will yield on that question in due course of time. It is opposed to a broadening of the service to include the free administration of anesthetics, but that will also be adopted when the government is ready to take the step.

During the recent arbitration proceedings the association stood out for a capitation fee of 13s. 6d., but accepted the 11s. originally offered by the government. It has gained only in unimportant directions, leaving no other conclusion than that the medical profession, as regards those who have accepted service on the panel, is today practically a branch of the State Medical Service and in a position of utter helplessness and therefore compelled to accept whatever is offered or whatever conditions or restrictions are imposed.

The sole objective of the investigation was to ascertain the facts and the present state of impartial and qualified public opinion in matters of detail. Much of the information secured was of a confidential character, precluding the disclosure of names at the risk of controversy. Every possible courtesy was extended to me on the part of the government and the medical profession to make the investigation thorough and complete. The practical difficulty, of course, lies in the correct interpretation of matters which lie so largely outside of the field of insurance and medical experience. My personal observations have been amplified by a careful reading of a truly appalling mass of official or semi-official literature on every phase of national health insurance. For the present purpose, however, I have relied in the main, aside from official publications, upon the letters contributed to the *British Medical Journal* since 1910, discussions in the *National Medical Journal*, issued by the National Medical Union, the *Medical World*, which is the official organ of the Medico-Political Union, the *Medical Officer*, a journal for medical men in the government and municipal services, the *National Insurance Gazette*, and *Sickness Societies Review*, a weekly paper devoted chiefly to the interests of the national health insurance act, the *Poor Law Officer's Journal* and the newspaper press, containing many valuable contributions on particular aspects of the act during its controversial stage or previous to the enactment of amendatory legislation. To summarize this immense amount of evidence would be absolutely impossible within the required limitations of a public discussion limited, as said before, and of necessity, to only the most important phases of national health insurance legislation and experience.

The result of the investigation justifies no other conclusion than that national health insurance is a conspicuous failure both as regards the interests of the public and the interests of the medical profession. The former has been sacrificed to a measure of relief and amelioration much nearer to a badly reformed poor law than to an act aiming at an efficient

social service compatible with modern standards of democracy and personal freedom. The good that the act has done could have been achieved with much less difficulty and at much less expense if certain recommendations of the Royal Commission on the Poor Laws had been adopted. The harm done is incalculable. The medical profession has been reduced to the status of a trade, with the practical certainty that the only solution of its economic difficulties lies in the direction of trade union methods, including the ultimate resort to a strike. That would not mean that the medical profession would refuse to treat the sick, but simply that the refusal would be equivalent to a denial of service under the national insurance act. (See letter "On the Right to Strike," *Lancet*, October 16, 1920.)

But, perhaps, the most sinister aspect of the legislation is the complete perversion of aims and ends as regards the future of public health administration and preventive medicine in the more restricted sense of the term. The defects of national health insurance in this respect have recently been brought to public attention in a report by Sir James Mackenzie and the staff of the St. Andrews Institute for Clinical Research, issued as an appendix to the report of the Inter-Departmental Committee appointed to consider and report upon the form of medical record to be prescribed under the terms of service of insurance practitioners contained in the Medical Benefit Regulations for 1920.* No one has rendered greater service to the cause of preventive medicine in the true sense of the term, as limited to the prevention of disease occurrence and as clearly differentiated from unnecessary prolongation or premature death, than Sir James Mackenzie in his masterly treatise on "The Future of Medicine,"† but the Memorandum referred to is a scathing indictment of the failure of national health insurance to square with the initial promise to prevent disease as well as to afford pecuniary relief in the event of its occurrence. The treatment of the sick under national health insurance is mediocre and often a mere apology for what is really required, particularly in serious cases where costly drugs and costly appliances are refused on the grounds of a parsimonious economy. Thus the interests of the public are sacrificed to political exigencies, and while much capital is made out of changes aiming at slight reforms, the root of the evil remains as before and sickness on a colossal scale continues with practically no serious reduction in the death rate from important and largely preventable causes. The best illustration in support of this conclusion is the phthisis death rate of females since the introduction of national health insurance, and which it may safely be assumed has remained unaffected by the war. Considering collectively the entire female population of England and Wales during the period 1911-13, when the act was in its initial stage, the death rate of young women, ages 20-25, from phthisis

*The "Future of Medicine," by Sir James Mackenzie, published by Henry Frowde, Oxford University Press, London, 1919.

†London *Lancet*, August 7, 1920, p. 310.

pulmonaris was 0.48 against 0.59 during the period 1914-17. There was therefore an increase of 0.11 per 1,000 of population, which must be considered a serious reflection upon the efficacy of measures of tuberculosis prevention and control. At ages 35-55 the phthisis death rate diminished from 0.58 per 1,000 to 0.53, or remained practically stationary; yet during the meantime vast expenditures have been incurred on the part of the public authorities more or less in cooperation with insurance committees, but practically without definite results upon the *health* of the population. The general death rate of females remained about the same during the last four years of the period under review, leaving no other conclusion than that sanatorium benefit as an essential element of national health insurance has been a conspicuous failure. This has been acknowledged by the government, and by recent parliamentary legislation sanatorium benefit has been removed from national health insurance as of January 21, 1921. Subsequent to that date the sanatorium administration in its entirety will be made the concern of the public authorities, as is properly the case in other countries.

In the words of Sir Kingsley Wood, M. P., Parliamentary Private Secretary to the Minister of Health: "As we stand today many of our women are not receiving the attention they need—National Health Insurance provides little for them—while as far as medical treatment is concerned the lot of the middle classes is in many respects wholly unsatisfactory." This is practically an official view-point, sustained by the results of my own investigation. The conclusion emphasizes the danger of radical legislation not based upon sound principles of public policy. In the words of Dr. H. Stainer Baker, of the Rushton Urban District Council, "Mankind stands more in danger from amateurish minds, unconscious of their limitations, than from frailty of the body." Reckless reform proposals are as common in England as in the United States, but the danger is greater in our own country on account of the more common disregard of the lessons of experience. It is argued, and with some degree of probability, that the proposed legislation in this country will not lead to similar results; but as a matter of fact the proposed laws for this country are decidedly more amateurish and more fraught with grave consequences than the English national health insurance act. It is said that the American bills were drafted with the cooperation of physicians and after the defects of the British situation had become apparent. No effective cooperation has been had any more than that the view-point of the British medical profession was given sufficient consideration in the framing of the British national health insurance act or the legislation passed subsequent to 1911. In plain truth, the vital interests and the considered view-points of the British medical profession have been ruthlessly disregarded, as clearly in conflict with political expediency. The truth of experience has been complacently ignored whenever inconvenient and the facts derived from official sources have been set aside. These aspects of

the controversy I have tried to emphasize in my previous publication on "The Facts and Fallacies of Compulsory Health Insurance," intended to place on record the truth of a situation which unquestionably involves the future of the medical profession as much as it imperils the future of democracy.*

It is easy to make light of this view-point, but nothing is more perilous at the present time than the unfulfilled promises of the government, solemnly made to an electorate able to think and reason for itself and to impose its will where the majority still rule. The government of every country is being assailed from every angle of political controversy, chiefly on the ground of insincerity and incapacity. The *New Statesman,* under date of September 4th, refers to the British government as follows: "It is not that the British Government has pursued wrong policies, but that it has had no policy and kept no faith. Under the direction of Mr. Lloyd George it has drifted, first in this direction and then in that. It has said one thing and done another. It has maintained its existence by an unbroken series of hand to mouth expedients and has forfeited every claim to confidence and respect at home and abroad." To no legislation of the British government adopted during recent years does this conclusion apply more emphatically and uncontrovertibly than to the national insurance act of 1911 and to the parliamentary debates and promises on the part of the government of the day and during the long intervening period of later years. It is for America to realize clearly the lessons of the British experience and certainly for the medical profession to arouse itself to the menace of the proposed legislation which threatens its very existence and, what is vastly more important, the interest of the patients, whose condition under national health insurance is but a degree removed from subserviency under a liberal poor law.†

Thus restating the conclusions of the present investigation in their application to the practice of medicine and as a matter of convenience, I would say as follows:

1. *Medical attendance* under national health insurance has deteriorated by being *standardized* to the point of mediocrity and to a degree even inferior to medical poor relief.‡

*See also the following: Facts and Fallacies of Compulsory Health Insurance (1917), Public Health Progress Under Social Insurance (1917), Autocracy and Paternalism versus Democracy and Liberty (1918), Failure of German Compulsory Health Insurance: A War Revelation (1918), Health Insurance and the Public (1919), More Facts and Fallacies of Compulsory Health Insurance (1919), National Health Insurance in Great Britain (1920), National Health Insurance and the Medical Profession (1920), Poor Law Aspects of National Health Insurance (1920), The Pharmaceutical Aspects of National Health Insurance (1920), National Health Insurance and the Friendly Societies (in press), Sanatorium Benefit under National Health Insurance (in press.)

†In the opinion of Sir Arthur Newsholme, the medical care of poor law-patients is superior to the medical attendance under national health insurance.

‡See my address entitled Poor Law Aspects of National Health Insurance, Prudential Press, Newark, New Jersey, 1920.

2. Medical attendance under national health insurance is chiefly concerned with *trivial complaints* involving a truly enormous unnecessary waste of labor time and of professional time necessary for more urgent medical and surgical needs.

3. *Medical diagnosis* has deteriorated into a routine and casual consideration of large numbers of patients whose ailments are only superficially recognized and given perfunctory consideration which will average less than five minutes to a consultation!

4. *Home and night visits* are as much as possible discouraged and surgical operations are frequently delayed. Anesthetics are not given as often as desirable and on account of the additional expense, not provided for under national health insurance. Patients are apprehensive of being prosecuted under the "behavior during sickness" rules, however rarely such rules may be enforced.

5. There is no provision for *specialist treatment,* while at the same time the provision for medical and surgical supplies or appliances is totally inadequate.

6. The *drugs* are prescribed under such restrictions as to economy, etc., that there has been unquestionably a material deterioration in pharmaceutical practice; prosecutions for overprescribing are a matter of sufficiently common occurrence to act as a serious deterrent in general practice. A heavy burden has also been placed upon panel doctors as a result of the routine procedure which must be gone through with to comply with the drug pricing and drug checking methods of local committees appointed for the purpose.*

7. The right to attendance being practically unlimited, there is a vast and *needless demand for medical care* on account of imaginary and often only trivial complaints, based upon the necessity of maintaining in force the certificate of incapacity which forms the basis of the pecuniary sick benefit paid for a period of twenty-six weeks' sickness duration and for an unlimited period as to disability benefit thereafter.

8. The right to sick or cash benefit depends upon a *medical certificate of incapacity for work,* although the term incapacity is not defined or strictly definable in a medico-legal sense. The result, however, has been that physicians ready to grant certificates without thorough inquiry are given the preference and certainly have less trouble with their patients than physicians with a more conscientious regard for the interests involved.

*For a brief abstract of my discussion of the pharmaceutical aspects of national health insurance, see the *Medical Record,* September 25, 1920.

A serious controversy has developed as to the acceptance of certificates from physicians not on the panel, and particularly has this been the case in Scotland.

9. The *employment of private physicians* is naturally encouraged by the practice of granting certificates of incapacity disassociated from a quasi-state medical service. The practice is objected to by the approved societies as opposed to sound business methods, naturally concerned with measures likely to reduce malingering or imposition to the lowest possible minimum.

10. The practice on the part of panel patients to employ private physicians regardless of their right to free medical attendance is increasing rather than diminishing. The result has been, and is, to further *divide the medical profession* into those who rely exclusively upon private practice and those who do not.

11. Panel doctors are allowed to carry on *private practice,* with the result that there is much conflict as to the respective rights and privileges of panel patients, who complain in many cases of serious discrimination. In large surgeries in congested districts it is the rule rather than the exception that private patients have a separate entrance and are given separate and preferential consideration.

12. The panel system rests upon a *capitation payment for medical attendance* in the manner that a doctor is paid a stated sum per annum for every name on his official list, hence he is not paid for services that are rendered, but rather for services that may be rendered as the occasion arises. An exception is the Manchester system of payment by attendance, which has much to commend it, although in the aggregate the payment made to doctors is precisely the same as under the per capitation system.

13. *The per capitation fee* at the present time is 11s. This amount has only recently been obtained after a prolonged struggle on the part of the medical profession, originally insisting upon a minimum demand of 13s. 6d. per annum.

14. In this as in many other vital matters the *British Medical Association* representing the panel physicians, who number about fourteen thousand, *has signally failed* to carry its point with the government, although presenting its case with admirable skill and infinite patience, considering the strong evidence in its favor. Among other important failures in this respect the following are deserving of special consideration:

First.—The Insurance Acts Committee of the British Medical Association failed to secure an adequate income limitation fully protecting private practice against unjust encroachments. It originally maintained a demand for an income limit of £104, yielding, however, to the government demand of a £160 limit, which during 1919 was increased to £250. Of course the higher the limit the larger the proportion of desirable patients withdrawn from private practice. It has recently been proposed by the Hanley District Council of the Order of Druids, that the limit of £250 should be raised to £320. This is merely a repetition of the German experience where the income limit has been raised from time to time, with the practical assurance of still further and more serious limitations upon the right to private practice.

Second.—The Association failed to retain the right of an unlimited panel, yielding after long discussion to the government demand for a limit of 3,000 names, which in certain areas has subsequently been reduced, under the new Medical Benefit Regulations, to 2,000 names, and even less. Of course the lower the minimum the less must be the income of the panel physician from panel sources, and the more urgent the demand for an increase in the per capitation allowances, since every additional shilling allowed represents collectively not less than £700,000 in additional remuneration per annum. It is clear that the pecuniary interests involved in discussions of this kind are of truly colossal proportions.

Third.—The Association failed to maintain its objections to the proposed restrictions on the freedom of panel transfers or the sale of panel practices at death or retirement. The pecuniary importance of this restriction is best illustrated by reference to the advertising pages of the *Lancet* and the *British Medical Journal*, which rarely fail to emphasize a panel practice as an additional vested interest.*

Fourth.—The Association failed conspicuously in its emphatic protest against the surrender of common-law rights and privileges on the part of panel physicians in matters of controversy or dispute or prosecution with the Ministry of Health. The powers granted to the Ministry in the making of rules and regulations or in the governance of proceedings are practically arbitrary and without the right or power of appeal to the courts.

15. The foregoing are but a few illustrations of the *diminishing influence of the medical profession* as collectively represented in its negotiations with the government and the obviously growing view-point that the status of the panel doctor is practically equivalent to that of a civil servant.

*See an important letter on this question in the *British Medical Journal* of October 9, 1920, by Dr. R. Douglas Howat, of Denholm near Hawick (p. 91).

16. In theory the profession is adequately represented on the several insurance and other committees administering national health insurance, but as a matter of fact the representation is largely nominal and carries with it little or no opportunity to effectively bring pressure upon the government to conserve the interests and the time-honored traditions of the profession. There has therefore developed a strong trend towards *a new form of organization*, best emphasized, on the one hand, by the Federation of Medical and Allied Societies, which recently made its first annual report, and, even more important for practical purposes, the Medico-Political Union, which squarely maintains the duty of the profession to reorganize upon the principles of a trade union and to adopt trade union methods in its negotiations with the government.

17. The Federation of Medical and Allied Societies, of which Sir Malcolm Morris is the chairman, on December 12, 1919, presented a series of reasoned conclusions to the Ministry of Health, maintaining that in the opinion of this conference the *draft regulations of 1920* proposed to be made by the Ministry of Health with respect to the administration of national health insurance medical benefit were not adapted to secure the most efficient service from the medical profession nor adequate results to the community. For, it was pointed out, the medical benefit under the act had been in force seven years, and although it constitutes the greatest experiment in public health legislation ever introduced, no facts were available by which to judge its success or failure! This viewpoint is shared by all who have impartially considered the facts and information available and who are emphatic in their conclusion that the system as at present in operation falls far short of the results anticipated from the legislation enacted in 1911.*

18. The profession is realizing the danger of profound changes in the future relations of the profession to the government and the public. The *never-ending controversies* over questions of remuneration and terms have had the effect of lowering the profession in the esteem of the public, for, as said by Sir Malcolm Morris, in his recent address, "The chaffering in public into which the profession was forced was only too well calculated to give the impression that medical men were thinking much of their material interests and very little of the nation's welfare."†

19. Hence the increasing demand from responsible sources, though largely outside of the medical profession, for a *state or public medical service*, on a part-time or whole-time salary basis. An entire literature has come into existence in advocacy of a state or public medical service,

*See letters in the *British Medical Journal* of October 19, 1920, on the Brighton and Dartford schemes for solving the problem of capital values of medical practices under the new regulations.

†The *Lancet*, July 31, 1920, p. 266.

and the National Medical Union, an influential organization, is strongly urging the conversion of national health insurance into a system of public medicine, limited to the necessitous poor. This proposal, in brief, has the endorsement of some of the strongest recommendations made by the Royal Commission on the Poor Laws, the findings of which were, broadly speaking, contemptuously ignored by the government of the day.

20. While the medical profession is unquestionably opposed to a state or *salaried medical service,* it must be self-evident to an impartial critic that the present confusion with its never-ending controversies cannot possibly continue without very radical modifications, for whether the panel doctor likes it or not he is, in fact, in the position of a quasi-state servant, with practically no effective powers left to maintain his earlier independent professional position.*

21. This is best emphasized in the new medical benefit regulations, which in many respects place the panel doctor in a *decidedly more dependent position* than heretofore. A panel doctor is subject in all matters of importance to the rules and regulations of the Ministry of Health, and accountable to government officials in a multitude of matters which in the past have not required any government interference whatsoever. This applies, for instance, to the kind of office accommodations he must furnish, to the office hours he must maintain, to leave of absence during vacation, to the appointment of successors in the event of his retirement or death, and last, not least, to the keeping of a multitude and increasing number of exacting records without adequate compensation.

22. *The official literature* of the numerous conferences between the Insurance Acts Committee of the British Medical Association and the government, supplemented by a truly enormous mass of official circulars, memorandums, etc., precludes a full grasp of an extremely complex situation. Some of the most important documents are almost unobtainable at the present time, particularly Form 43 I. C., which brought forth from the National Medical Union the suggestion that no member should sign this or any similar form. In December, 1914, there was issued a Memorandum known as 211 I. C., which threatened to attack the non-panel doctor's right to give a certificate by stating that only an approved form would be considered for the giving of medical benefit, and this was issued to panel doctors only. Attempts were made at the time to withhold sickness benefit and to reject certificates of non-panel practitioners by insurance committees and by some approved societies, but the matter was finally adjusted. It would be utterly impossible to review the entire mass of

*See the *British Medical Journal* of June 12, 1920, on "The Future Provision of the Medical Services," also a letter by Alexander Blackhall Morrison, in the same issue, and an editorial on the subject in the *Lancet* of July 24, 1920. Of special value in this connection is a discussion of the "Future of Medical Practice," by Dr. Peter MacDonald of York, *British Medical Journal,* September 18, 1920, p. 450.

official circulars, publications, etc., on the subject, but I have reviewed all the more important, giving full references to their titles, so that for the first time access may be had to what constitutes the most trustworthy source of information on the actual operation of national health insurance in its relation to the medical profession. The national health insurance act reads in its preamble that the objective of the proposed legislation is primarily for the prevention of sickness. Nothing contained in the act, however, makes provision for *the prevention of sickness occurrence*, for medical attendance and pecuniary assistance during sickness are in the nature of relief and cure and only remotely connected with prevention in the true sense of the term. The death rate from tuberculosis during the period 1914-1918, and in its particular bearing upon the female population, shows a marked increase over the earlier period during which national health insurance was not active or equally extended in its operation. The vast sums expended through a needlessly complicated bureaucratic machinery represent an equivalent withdrawal from the funds which would have been available for effective health promoting activities, rather discouraged than encouraged by national health insurance.

No one has spoken more courageously and to better purpose on this most lamentable aspect of the subject than Sir James Mackenzie, the Director of the St. Andrews Institute for Clinical Research and the distinguished author of an epoch-making treatise on "The Future of Medicine." In a recent report to the government Sir James Mackenzie points out that the diagnoses made under national health insurance "are for the most part imperfect and statistics based upon them are misleading, because the classification is at present based upon morbidity changes which have been discovered after death." He observes further, "the incompleteness of medical knowledge at the present time is clearly shown by the fact that a very large number of patients who consult their doctor and who are incapacitated from work do not suffer from any disease referable to the current classification or one which can be detected by physical signs. They suffer from disabling symptoms not referable to the disease of any special organ." But no progress has been made under national health insurance, nor is there any promise of such progress, under the conditions common at least to panel practice in all the larger and more congested and industrially most important districts. (See Appendix I.)

23. Hence the incontrovertible evidence that the alleged aims of national health insurance are subordinate to its true function as *a measure of economic and superficial medical relief*, perilously near to the earlier conditions of a recklessly administered policy of outdoor relief for the poor, and hence the sinister aspect of modern industrial life in Great Britain, where the entire wage-earning population is once more being pauperized, as was the case under the poor law of 1601 by the time of its radical reform in 1832.

24. *Public dependence* in England or reliance upon the state for all kinds of measures of amelioration and relief has since the introduction of national health insurance grown at a really prodigious rate. Non-contributory old-age pensions have been increased from 5s. to 10s. per week. Unemployment insurance has been increased from 11s. to 15s. Cash benefits under national health insurance have been increased from 10s. to 15s., and all war pensions have been raised to a rate which practically precludes the exercise of individual thrift.* It is a gross perversion of accepted terms to speak of "*compulsory* thrift," when the very essence of thrift is voluntary effort and voluntary abstinence from the current use of earnings laid aside as a future provision in the event of sickness, disability or old age.†

25. The present agreement of the British Medical Association with the government cannot be looked upon as a solution, for there are the strongest indications of *widespread dissatisfaction* with the award and of a growing determination to bring about a reconsideration of the case. It is not generally known that while theoretically the capitation fee of 11s. is supposed to be paid, as a matter of fact in many settlements, often unduly delayed, the doctor receives much less than what he apparently is entitled to. This is due to the condition of the Medical Benefit Fund, arrived at by intricate calculations, and the apparent impossibility of accurate panel lists precluding the risk of serious inflation. Such inflation would operate in favor of some physicians while opposed to the interests of others. It is probably safe to say that, as judged by the Manchester experience, the doctors generally receive only from 75 per cent. to 85 per cent. of what they believe they are justly entitled to, on the basis of their own calculations for services rendered.

26. The doctors being required to fill out *prescription blanks* in accordance with the rules and regulations of the Ministry of Health for the purpose of price checking and analysis do not seem to realize that this

*The evidence is entirely conclusive that there has been no diminution of poor law dependence, but that quite to the contrary the poor rates are increasing all over England and possibly Scotland. I have reviewed this phase of the problem in a discussion on "The Poor Law Aspects of National Health Insurance," read before the National Conference of Social Work, New Orleans, April 21, 1920. Vagrancy, which touches upon the most vulnerable aspect of national health insurance or, in other words, the medical provision for the poorest poor, is alarmingly on the increase, while it is practically a foregone conclusion that a vast amount of voluntary or involuntary unemployment will occur during the coming winter, which must needs impose heavy additional burdens upon a system which gives a direct incentive to malingering and the unnecessary prolongation of minor ailments. Cases are increasing in poor law practice in which it is found upon inquiry that sufficient means exist to preclude the necessity of poor relief. The *Poor-Law Officers' Journal,* under date of September 3, 1920, reports a case of a family seeking public assistance, although in receipt of a joint income of £900! To this family, the Relief Committee granted 35s. a week, which, it is properly pointed out, "was putting a premium on laziness." The apparent decrease in the number of persons relieved since 1911 is offset by the old-age pensions, which now number nearly one million at the rate of 10s. a week or less! Under the amended old-age pension law, guardians are now allowed to pay out the relief and the old-age pension simultaneously, as long as the income is kept within the statutory limit. This is an entire reversal of the policy of the act of 1908, indicating, as pointed out in the *Poor-Law Officers' Journal,* October 1, 1920, "that the sentiment which would keep the two organisations separate, was breaking down under practical experience." A similar result is a foregone conclusion in the case of national health insurance, which must, therefore, be looked upon as primarily a supplementary poor law.

†Maternity benefit has been increased from 30s to 40s.

method may in course of time, as perhaps it should, be extended to require the entry on the prescription blank of the nature of the disease on account of which the prescription was rendered. If this requirement were insisted upon by the Ministry of Health a truly enormous amount of new information concerning medical practice would become available to the government and to the public. Such a requirement would for the first time precisely coordinate the treatment of disease to its tentative diagnosis. In course of time no doubt this might be further enlarged in the direction of a coordination of the death certificate giving the terminal diagnosis to the prescription indicating the tentative clinical diagnosis. The prescription blank certainly has placed in the hands of the government a far-reaching element of control and supervision over the medical profession for the time being considered entirely out of the question.

27. If there is danger of the establishment of a State or Public Medical Service, there is at the same time a growing menace of the establishment of a *State Pharmaceutical Service*. Such a tendency is becoming quite apparent in continental European countries and seems to have been carried into effect in Vienna as a check upon profiteering and on account of the required public economy in drug prescribing.

28. The broadening of unemployment insurance, which under the Act recently passed is practically inclusive of the identical population insured under national health insurance, suggests the ultimate combination of the schemes into one large measure of assistance and relief based upon the principle, as yet but vaguely realized, that incapacity for work is of itself a fundamental concept irrespective of the reasons why such incapacity may exist or continue. It certainly is a grotesque perversion of governmental effort to maintain two enormously expensive and complicated agencies for serving precisely the same purpose; for to the beneficiary under the Acts it is quite immaterial whether he receives 15s. a week on account of unemployment or because of unemployment due to some more or less serious disabling form of sickness. Just as in the case of unemployment insurance, reliance is placed upon out-of-work or labor exchanges, etc., so in the case of sickness insurance reliance is placed upon methods of disease treatment rather than disease prevention, however imperfectly developed at the present time. The sole objective of either Act must be in the long run to restore the person to a working capacity, whether for economic or medical reasons is quite immaterial. Problems of prevention must therefore assume secondary importance if only because of the direct incentive to prolong idleness, especially during periods of industrial depressions and low wages. However disagreeable the truth, a governmental policy which deliberately encourages malingering and voluntary idleness cannot be looked upon otherwise than as "the road to ruin."

These conclusions square with the facts as derived from a variety of trustworthy sources representative of the nature and considered viewpoint of thoroughly responsible and impartial British public opinion of today. They recall the words of the late W. H. Lecky, that "the fatal vice of ill-considered benevolence is that it looks only to the proximate and immediate results without considering either alternative or distant and indirect consequences." It is with the latter that the present investigation has been chiefly concerned, leaving no alternative to the conviction that in the long run the character of the wage-earning element must suffer material deterioration under any form of social insurance resting upon the principle of compulsion and resulting in dangerous class distinctions while enormously enhancing the powers and functions of the autocratic socialistic state.*

*Since this was written, the Ministry of Health has issued its first annual report, part I. of which concerns the public health, including medical benefit under National Health Insurance, part IV. dealing separately with matters of administration of National Health Insurance only. The reports fail to present a consolidated account of the national experience as a whole in a manner useful for the practical purpose of determining elements of cost and efficiency. (Cmd. 923, price 1s. 6d.). Of special interest is the following significant passage on the drug trade (p. 71):

"In connection with the revision of the financial arrangements governing the payments to doctors, the system under which the doctors had a *speculative interest* in the amount of the drug fund has been abolished. Prior to 1920 the doctors received a share of what was called the "floating sixpence," which meant that where the cost of drugs in any area exceeded 1s. 6d. per head of the population, but did not exceed 2s., the saving on the drug fund went to swell the amount of the credits in the areal pool out of which doctors were paid. Under the new arrangements the doctor receives an inclusive capitation fee, and for checks on excessive prescribing reliance is placed on the machinery previously set up by the regulations, and continued with additional safeguards, under which the panel committee in the first instance determines whether any individual doctor has been unnecessarily extravagant in prescribing."

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NATIONAL HEALTH INSURANCE AND THE MEDICAL PROFESSION*

Introduction

The subject matter of national health insurance is so extensive that it is possible to consider to practical advantage only special phases in their particular relation to special interests. It would hardly serve a useful purpose, for illustration, to present the poor law aspects of national health insurance to a medical audience, just as, conversely, the labor aspects would not be of particular interest to the medical profession. For the present purpose, therefore, the following considerations will, as far as possible, be limited to the actual or probable future effects of a state system of compulsory health insurance upon the medical profession, as representing the practice of medicine as a healing art and to a lesser extent as the administration of public health through sanitary officers. On account of the extreme complexity of the problem it will not be advisable to include in the present discussion extended observations on the effects of the British method of national health insurance on the pharmaceutical profession or the drug trade, which I hope to make a matter of separate consideration some time in the future.†

There, no doubt, is much ground for believing that the medical attendance of the poor and the moderately well-to-do previously to the passing of the national health insurance act was not satisfactory. But mediocrity in treatment has, to a large extent, continued and become practically standardized under a system which rests upon the conception of a general practitioners' service "consistent with the best interests of the patient, such as can properly be undertaken by a general practitioner of ordinary professional competence and skill" is considered sufficient for the purpose. Unquestionably, as a broad principle in every-day life, such a theory must needs apply to a large number of cases which are not re-examined and made subject to a critical review by men of real ability and rare skill. The danger is that when such a principle becomes a statutory definition,

*A consolidation of papers read before medical societies of New Jersey, New Haven, Conn., New Orleans, La., Cleveland, Ohio, Minneapolis, Minn., Wilmington, Del., and Philadelphia, Pa.

†The British Medical Association originally maintained the following six fundamental principles:

1. An income limit of £2 a week for those entitled to medical benefit.
2. Free choice of doctor by patient subject to consent of doctor to act.
3. Medical and maternity benefits to be administered by local health committees and not by friendly societies.
4. The method of remuneration of medical practitioners adopted by each local health committee to be according to the preference of the majority of the medical profession of the district of that committee.
5. Medical remuneration to be what the profession considers adequate, having due regard to the duties to be performed and other conditions of service.
6. Adequate medical representation among the insurance commissioners, in the Central Advisory Committee, and in the local health committees, and statutory recognition of a local medical committee representative of the profession in the district of each health committee.

The association carried most of these points except the income limit of £104 a year, which by the government was fixed at £160 and has since been raised to £250.

no further progress, or, at least, no material progress, will be made in the direction of perfecting medical practice, such as inevitably results from a condition of free competition. In the report on the Organization of Medical Attendance made to the British Medical Association in 1911, in response to a resolution adopted, however, in 1909, it is said that "the records of the association overflow with evidence that most of the existing arrangements for medical attendance upon the wage-earning classes are unsatisfactory to the medical profession," and that, therefore, "the profession must be prepared for the probability of action being taken in some form by the community, whether with or without the sympathetic cooperation of the profession, or even in disregard of the profession, which must profoundly modify existing conditions of medical practice among the wage-earning classes." (*British Medical Journal*, March 4, 1911.)

The action foreshadowed was the introduction of national health insurance, the medical benefit provisions of which became operative on January 12, 1913. Some time during 1917 the Insurance Acts Committee of the British Medical Association made an official report on the future of the insurance acts, in which it is said, in the light of the experience which had been had in the meantime, that "many hold that the service is inadequate, both in extent and in quality, and that it carries with it a taint of cheapness and semi-charity, which would have no place in a system which was not provided for paupers and for which the state is responsible," and that, furthermore, "all are agreed that the present panel system is imperfect and in any improvement, reconstruction or explanation of the system, it is desirable that such modification should be made as to attract to the work as many practitioners as possible." (D. 19, p. 2). These anticipations have not been realized, but the experience which has been had suggests a thorough inquiry on the part of the American medical profession into all the facts which demand consideration, in place of the superficial and largely misleading arguments brought forward by those who for professional or other reasons are making propaganda for a compulsory health insurance system in this country.

Principles of Medical Service

It is generally agreed that the success of any system of compulsory health or sickness insurance rests essentially upon the whole-hearted cooperation of the medical profession. Regardless of the earlier view-point of propagandists for compulsory health insurance, that the primary consideration is the payment of a cash benefit, it is now generally agreed that the main objective, at least from the view-point of the government, is or should be an adequate auxiliary system of medical attendance, inclusive or exclusive of the members of the insured person's family, as the case may be. The following observations are chiefly concerning the results under the British national health insurance acts, which, it is hardly necessary to point out, differ in many important essentials from the German acts, though in the

main largely conforming to the principles and methods of the German legislation.*

The Panel System

It would be of interest to trace the historical development of the British medical profession to national health insurance, but this would unduly enlarge the present discussion. It may be said, in brief, that a strong opposition at the outset has gradually given way to a ready acquiescence in a system which it is generally agreed has come to stay. That system is unquestionably a modified form of public medical service, though not clearly recognized as such on the part either of the government or of the medical profession. The fundamental conception is the so-called "panel" system and the payment of a per capita fee for medical services, which may or may not need to be rendered, as the case may be.† The origin of this conception of compensation is to be found in the old club or contract practice, which by 1911 had practically reached a point where a payment of 4s. per insured person per annum was considered reasonably adequate for ordinary needs.‡ Obviously, however, everything depends upon the nature of the required services, which in the British act are defined as follows: "The practitioner shall give to all persons who are for the time being entitled to obtain treatment from him such treatment as is of a kind which can consistently with the best interests of the patient be properly undertaken by a general practitioner of ordinary professional competence and skill."‖ In practice this definition has been variously construed, although on the whole there is a fair consensus of agreement as to what is and what is not required to be done.§ Broadly speaking, the services rendered represent a minimum of professional attention, practically limited to ordinary ailments not requiring the assistance of con-

*It would be utterly impossible to discuss with the required completeness the long trouble experienced by the British Medical Association in retaining for itself the status of an independent body primarily concerned with the interests of its clients. The evidence is contained in probably more than a thousand pages supplementary to the weekly issues of the *British Medical Journal* from 1910 to 1920. This evidence is invaluable to American students and reflects the painstaking care with which members of the British medical profession brought their frequently conflicting views before the public. The profession has had to fight much bitter opposition from friendly societies and other interests concerned primarily with the economic aspect of health insurance, rather than with the most efficient administration of its medical provisions. Even Mr. Lloyd George himself placed upon record the remark that "this is not a doctors' bill." Words well said at the time, and not likely to be forgotten.

†"Medical Benefit in Scotland," W. M. Marshall, Motherwell, 1917, p. 4.

‡The objections to the capitation payment system have been ably set forth in the report of the British Medical Association on the Organization of Medical Attendance, reprinted in the supplement to the *British Medical Journal* of March 4, 1911, pp. 103-105. In connection therewith should be read the observations on payment by attendance in the same report.

‖"Everybody's Guide to the National Insurance Acts, 1911-1913." Thomas Smith, p. 125.

§An important statement occurs in the minority report of the Royal Commission on the Poor Laws and Relief of Distress (Vol. III, p. 390), where it is said that the new poor law proposed by the majority is therefore "no longer to be confined to dealing with *'the destitute'*; it is to provide for the much larger class of *'the necessitous.'* " This term has come into general usage at the present time in proposals for a system of state or public medicine. Profoundly suggestive is the qualification that all governmental efforts dealing with the interests of the poor tend more and more to fall into the hands of persons "who, caring more for their own interests than for those of the community, direct their administration more towards the attainment of popularity than towards the solution of the real problems of pauperism." The same conclusion may properly be applied to any form of state medical service based upon class distinctions not different in its essentials from panel medical service under national health insurance.

sultants or more than the most simple operative interference. It is provided under the act that "the practitioner shall not by virtue of the agreement be required to give nor be entitled under the agreement to make any charge for treatment to any person in respect of a confinement (that is to say, labour resulting in the issue of a living child or labour after twenty-eight weeks of pregnancy resulting in the issue of a child, whether alive or dead), nor to any person suffering from tuberculosis or any other disease the treatment of which may hereafter be included in sanatorium benefit, in so far as that person has been recommended for and is entitled to obtain that treatment as part of his sanatorium benefit."

It is furthermore provided that "where the condition of the patient is such as to require service beyond the competence of an ordinary practitioner, the practitioner shall advise the patient as to the steps which should be taken in order to obtain such treatment as his condition may require." These requirements clearly show the restrictive nature of the services and indicate the resulting complications in every-day practice, most of all on the part of physicians having a large panel to care for.*

The Remuneration of Panel Practice

The "panel" represents a list of persons who have agreed to the medical service on the part of a specified practitioner, subject to the freedom of choice or change which formerly could be made once a year, but which under recent changes can be made twice a year. This freedom of choice was originally made much of as an attraction to the service and the protection of the physician's personal interests.† In practice the freedom of choice has not been exercised to the degree anticipated and the changes from one panel to another or from one practice to another will probably not exceed five per cent. of the total number on a panel during the course of a year. This fact has been clearly brought out in discussion having reference to the transfer or sale of a panel practice at the death of a practitioner, which frequently constitutes the sole heritage of a deceased physician left for the protection of his surviving family. The question involved here cannot be dealt with at length, but broadly speaking the term "freedom of choice" is a misnomer, though readily agreed to on the part of a large proportion of the membership of a panel transferred to the services of a practitioner with whose professional qualifications they cannot possibly be familiar.‡

*See statement of the chairman of the Manchester Insurance Committee to the effect that "the majority of the complaints were that insured persons do not get the medicine they really require," but he was unable to bring the complaints forward in the proper manner, because they could not at the moment be substantiated by sufficient evidence. This complaint was recently brought to public attention in a communication to the Birmingham *Post* of September 15, 1919, by Mr. J. H. Brown, in behalf of the Sons of Temperance Society, who complained "of doctors not being allowed to prescribe as they would if they had a free hand, owing to the fear of being sur-charged." As a result of this effort to economize, their members were kept on the books longer than would otherwise be the case. As a remedy he presented a resolution of a society of 250,000 members "strongly urging the immediate institution of a state medical service, believing this would be the best course in the interests of the health of the nation, and more equitable for rich and poor alike."

†Marshall, Medical Benefit in Scotland, p. 4.

‡For an outline of recent discussions on the questions of mileage, remuneration, panel limitations, etc., see page 29, *et seq.*

What freedom of choice can there be under a system which allows a change of doctor twice a year? What is there to be gained by the changing of doctors and the reducing of standardized medical practice to the level of poor law medical relief? The insured person is compelled to seek a panel doctor whose methods of treatment will differ from those of other panel doctors, at least in the case of large panels in industrial districts.

In a letter to the *British Medical Journal* of May 20, 1911, Dr. Davis, of Bristol, took occasion to point out that "the scheme is to be worked by friendly societies and local authorities, both of which bodies are in deadly opposition to the principle of free choice of doctor. This means that one doctor will be employed at the comparatively large salary of £500 and three other doctors will be cut out from the scheme and will have to live on the picking of private practice among dependents and those few persons above income tax limit who prefer not to come into the scheme."*

Rules for Panel Practitioners

It will subsequently be shown that this view-point is clearly recognized by the Ministry of Health and fully emphasized in the new regulations, which restrict the sale of panel practices to the pecuniary disadvantage of individual practitioners in particular cases.† Before proceeding it may not be out of place to emphasize that the medical as well as general administration of national health insurance is now under the Ministry of Health. But this branch of the public service includes a number of widely diverging interests, from the administration of the public health to housing reforms and the poor law. The Ministry is fortunate in having as its chief medical officer Sir George Newman, a man of large experience and much breadth of vision, as best illustrated in his recent public papers on preventive medicine and the required changes in the public view-point as to the true function of an effective public health administration.‡ Nevertheless, the general effect thus far at least has been to bureaucratize the medical profession and to bring about a degree of supervision and control in matters of detail wholly unanticipated when the British Medical Association in 1911 finally agreed to the proposals of the govern-

*It is exceedingly suggestive in this connection that it should have been said in the report of the minority of the Royal Commission on the Poor Laws and Relief of Distress (Vol. III, 1909, p. 393) that "What seems to us even more extraordinary is the proposal to grant to every destitute sick person the privilege of free choice among the doctors of the town, exactly as if such persons had belonged all their lives to a well-organized Provident Dispensary. If it is desired to make relief less desirable than the maintenance by individual exertion and foresight, we should have thought that 'free choice of doctors' was exactly the privilege to be withheld from the person coming to the rates for treatment. The proposal seems to us all the more dangerous as it is plain that the poor patient will tend to choose the doctor who interferes least with his habits, and whom he finds most sympathetic in ordering 'medical extras'; from which, it must be remembered, food and even alcoholic stimulants are not excluded."

†See Medical Benefit Regulations, 1920, First Schedule, Section 4, p. 33.

‡The views of Sir George Newman have been presented in an admirable "Outline of the Practice of Preventive Medicine," London, 1919, price 6d., obtainable through Messrs. P. S. King & Son, Great Smith Street, London.

ment to accept service in behalf of its members under the national health insurance act.*

The Insurance Acts Committee

The interests of the organized medical profession are cared for by the Insurance Acts Committee of the British Medical Association and by special panel and other committees representing the profession in matters of local concern. The proceedings of these committees are extremely interesting, but the results hardly permit of being presented in the form of a brief generalization. The reports of the Insurance Acts Committee are unfortunately not properly numbered or dated, so that it is difficult to make sure that even the more essential documents are completely represented. The more recent of these publications to which reference may be made on this occasion are the following:†

D 8, 1916-1917, report on the future policy of the British Medical Association as regards national health insurance, January, 23, 1914;

D 9, 1916-1917, question to branches, divisions, local medical committees and panel committees;

D 18, report on the future of the insurance acts, June 16, 1917;

D 19, 1916-1917, being the interim report on the future of the insurance acts, June, 1917. (A most valuable document, including reasoned conclusions of the committee on every essential aspect of medical benefit legislation.);

M 3, 1918-1919, being the interim report by the Insurance Acts Committee on the method of calculating the remuneration of doctors under the insurance (health) acts;

M 18, 1918-1919, being notes by the rural practitioners' sub-committee on the constitution and distribution of the mileage or traveling funds;

M 19, further interim report by the Insurance Acts Committee on the method of calculating the remuneration of doctors under the national health insurance act. (A brief but exceedingly interesting and valuable document, London, 1918.);

M 25, 1918-1919, being a report on the revision of the condition of service under the national health insurance acts and the possible extension of the service, May, 1919;

*Of material value in considering the panel system is a small treatise on the "Panel Doctor" by T. M. Tibbetts, John Bale Sons and Danielsson, London, 1918, price 2s. 6d. Thus far no comprehensive work has been forthcoming dealing with the financial aspects of the doctors' side of the question. A work of some value, though of an earlier date, is Medical and Sanatorium Benefit Regulations, by J. Henry Lloyd, London, 1914.

†Also the communications of the British Medical Association on Insurance Practitioners: June 8, 1917, September 24, 1917, March 16, 1918, September 28, 1918, July, 1919.

Memorandum issued in 1919 (not dated), entitled "Memorandum of Discussions on Certain Questions of Provision of Medical Services at Five Conferences of Members of the Medical Profession Convened by the National Health Insurance Commissioners;"

Sixth quarterly circular to insurance practitioners, November, 1919, concerning new regulations of 1920 as proposed by the Ministry of Health;

M 26, 1919-1920, being rejoinder to the Ministry of Health on remuneration to insurance practitioners;

Letter dated January 14, 1920, of the Ministry of Health on new terms and conditions of service for insurance practitioners;

Letter dated January 14, 1920, of the Ministry of Health on new terms and conditions of service for insurance practitioners;

Letter with reference to the arrangement for the pharmaceutical service, dated January 22, 1920; and subsequent

Letter, dated January 30, 1920, on the remuneration of doctors with particular reference to the appointment of a committee on arbitration.

Aside from the foregoing, and of present importance, are:

Memorandum 187 I. C., with reference to the introduction of the medical card system;

Memorandum 191 I. C., with regard to persons making their own arrangements, London, February, 1914;

Memorandum 215 I. C., on procedure in cases considered by the Insurance Acts Committee in a judicial or semi-judicial capacity;

Memorandum 261 I. C.;

Memorandum 261a I. C., with regard to the arrangements to be made under the revised terms and conditions of service, set out in a draft of the medical benefit regulations, 1920, London, December 10, 1919;

Circular A.S. 166, on supervision of claims for sickness or disablement benefit, including a new system of medical certification, sick visiting and medical referees, London, December, 1914;

Memorandum of Insurance Acts Committee with reference to the administration of medical benefit, submitted by the Ministry of Health under date of October 31, 1919;

A further memorandum with reference to revised terms and conditions of service, dated December 10, 1919;

M.C.1, on terms of service for insurance practitioners, with particular reference to admission to and withdrawal from medical list and related matters;

M.C.2, on the allocation scheme prepared jointly by the Insurance Committee and the Panel Committee under article 15 of the national health insurance (medical benefit) regulations, 1920;

M.C.3, being the distribution scheme or the method of distributing the practitioners' fund, including calculation of lists frequently referred to as "actuarial" although not involving mathematical considerations.

Statements as to the administration of medical benefit and correspondence thereon between the Chancellor of the Exchequer and the British Medical Association, C.d. 6520, London, 1912;

Report of Departmental Committee appointed to consider the supply of medicines to insured persons, Vol. I, C.d. 6853, London, 1913, price 2½d.;

Report of Departmental Committee appointed to consider the supply of medicines to insured persons, Vol. II, evidences and appendices, C.d. 6854, London, price 1s. 4d.

The foregoing publications, papers and reports are but a fragment of a truly enormous literature, which has never been subjected to critical examination by those familiar with the facts of actual experience. Such a task is now practically beyond the power of any one man, or even of a group of men, sufficiently occupied, as they would be, with the flood of current reports, rules, regulations, circulars, etc., frequently effecting profound changes in matters of law and procedure. Historically the most useful information is contained in the parliamentary debates, which practically begin with 1911 and which have continued, regardless of the war and other profoundly important political questions, to the present time. Even more useful for the present purpose is the information contained in the *British Medical Journal*, which, with commendable enterprise, has given the utmost publicity to every view-point on every phase of the controversy. Beginning with the first week of January, 1911, there has never been an issue of the *British Medical Journal* that has not contained some information of value concerning some special phase of national health insurance legislation. The volumes of 1911 and 1912 bear witness to the strenuous efforts made by the profession to meet a political situation suddenly forced upon it, not for reasons of social welfare, but primarily as a matter of political expediency. The supplement contains an out-

pouring of letters representing every shade of qualified opinion, with which there is nothing to compare, or to contrast, in the history of medicine. If a fraction of the invaluable time and thoughtful consideration had been given to any particular disease or ill-health producing condition, the profession would have brought about changes which would reflect the true pride and progress of medicine as a healing art and as a force of large possibilities in the field of sanitary science and personal hygiene. Those who are concerned with the ascertainment of the truth of an extremely complex situation must ever feel profoundly grateful to the British Medical Association and the editor of the *British Medical Journal* for the fearless and broad-minded presentation of all the facts, which, if thoroughly considered and understood, would serve as a warning to any and every other country not to follow in the footsteps of this fatuous experiment in medical socialism, which borders on medical chaos and crime.

The Medical Benefit Regulations, 1920

The latter aspect of the present discussion is covered by the new medical benefit regulation promulgated by the Ministry of Health for the year 1920, including seventy specific rules and regulations and a number of highly involved appendices or additional schedules with reference to admission to and withdrawal from the medical lists; range of a practitioner's duties; the evidence of a person's title to obtain treatment; definition of persons for whose treatment the practitioner is responsible; and, most important, the arrangement for a practice on the retirement or death of the practitioner, to which a brief reference has previously been made.* These rules and regulations, which have the force of law, are officially known as "Statutory Rules and Orders, 1920, No. 301," and are dated February 23, 1920. It is urgently suggested to all who desire to thoroughly understand the complex relation of the medical practitioner to the government to obtain a copy of these rules, and in addition the reports of the Insurance Acts Committee of the British Medical Association, particularly M 25, 1918-1919, which better than any extended discussion emphasizes the inevitable growth of a bureaucratic service interfering, though often necessarily so, in matters commonly regarded as only of private concern.

Sources of Recent Information

The highly controversial aspects of the medical service under national health insurance are not, however, in their fullness represented by these official or semi-official communications. The most trustworthy source of information is the Weekly Insurance Supplement to the *British Medical Journal,* which contains a truly tremendous mass of data indispensable

*See Medical Benefit Regulations, 1920, First Schedule, Section 4, p. 33. Obtainable from Messrs. P. S. King & Son, 2-4 Great Smith Street, Westminster, London, W. S. 1, England, price 6d. net.

The new regulations have been made a subject of extended consideration in a series of articles contributed to the *Medical World,* London, June 4 to September 17, 1920. Articles are by Mr. Sidney G. Davis, O.B.E., Solicitor of the Supreme Court.

to those who seek for the whole truth in a matter of the utmost importance to the American medical profession. In addition there are the practically countless reports of local medical committees and sub-committees of insurance committees which cannot be referred to in detail otherwise than that it may be said that one of the most suggestive of these reports is "On the Revision of Conditions of Medical Service," issued by the Manchester Insurance Committee, under date of September 4, 1919.* For a popular statement of exceptional value on the administration of Medical Benefit in Scotland, a publication by that name should be consulted, issued by Mr. W. M. Marshall, clerk to the County of Lanark Insurance Committee, Motherwell, Scotland, 1917.

Discord in the Profession

The number of circulars and reports issued by the insurance commissioners of England, Wales, Scotland and Ireland, bearing upon important questions concerning medical practice, is legion. Particularly is this true when the broader aspects of the question are considered, or with reference to the treatment of tuberculous persons and the auxiliary pharmaceutical services provided under the act. These documents reveal throughout a high order of bureaucratic efficiency which cannot but be considered admirable, however much it may seem that a large measure of the efforts aims rather at the perfection of a system than at the legitimate objective of urgently required reforms. There can be no question of doubt, considering the widely different conceptions of law and administration procedure, that in the event of a similar system of compulsory health insurance being established in one of the several states the difficulties of harmonious relations would be even more serious than in England, Wales and Scotland, to which at the present time the application of medical benefit under the national health insurance acts is limited.† As an illustration, however, of the practical difficulties which have arisen, reference may be made to the five volumes of reports of Inquiries and Appeals under Medical Benefit Regulations, which contain some extremely suggestive cases, which it may safely be assumed are far from representing the full extent of the prevailing discontent on the part of both the medical profession and the public.‡ Thus, for illustration, according

*See also Report on Manchester System of Medical Service, Manchester Insurance Committee, October 20, 1914. The more important additional publications of the Manchester Insurance Committee on this phase of the discussion are as follows: (1) Rules for the Administration of Medical Benefit, February, 1915; (2) Forms of Account for Medical Service Rendered to Men Invalided from H. M. Forces, Receiving Treatment under Special Arrangements Applicable to Such Men (n.d.); (3) Statement made by the Chairman at the Meeting of the Insurance Committee on the 28th of November, 1916, with Reference to Medical Benefit; (4) Insurance Committees' Consolidated Regulations, 1916, and General Provisions Relating to Procedure of Insurance Committees, Manchester, November 28, 1916; (5) Revision of Conditions of Medical Service, September 4, 1919. (Of value in this connection also is a report of the Medical Service Sub-Committee of the Insurance Committee of the City of Liverpool, containing a list of cases in controversy with the medical profession.)

†The act does not apply to the Isle of Man, although strenuous efforts have been made to induce the local authorities to establish such a system. It may be said in this connection that the health of the island is thoroughly satisfactory and that there has been about the same rate of progress as in England and Wales, *without* health insurance, in response to broader view-points concerning both public health and medical practice. A law providing for a health insurance system has, however, recently gone into effect.

‡See Manchester Insurance Committee Report.

to the London *Evening News* of September 9, 1919, a Panel Patients' League has been formed, since, "under the present system of unlimited panels there is clearly a premium on scamping and inefficiency," and, furthermore, because "large and increasing numbers of insured persons prefer to consult a private doctor, at their own expense," although "they have to pay their weekly contributions nevertheless."* It is argued in this connection that panel doctors will not pay visits that can possibly be avoided, and that for this and other reasons "the remedy for the present scandal is the formation all over the country of associations of insured persons or, better still, of protest leagues to which both insured persons and their employers can adhere." Such a league, it appears, was to be formed in the Stafford section of the Midlands, but further information is wanting as to whether the suggested movement has become a reality.

Panel vs. Non-Panel Practice

The foregoing fails to convey the true extent of public dissatisfaction with the administration of medical benefit under national health insurance. According to an article in the *Scotsman* (April 8, 1919), "whatever else the Act may have done, one undoubted result has been to divide the medical profession into panel and non-panel members almost equal in number and looking at medical practice from different and varying standpoints," and, furthermore, that "the radical fault with the medical part of the scheme is unwarrantable interference and dictation in a department of life where the individual ought to be left free. The state has no more right to have a panel or list of doctors to be compulsorily paid for, whether employed or not by the persons compelled to pay, than to have panels of the clergy, or of lawyers, shopkeepers or washerwomen."

In the report on the Organization of Medical Attendance (*British Medical Journal*, March 4, 1911) occur some exceedingly interesting observations on club versus private practice, of which I can give only brief extracts, as an illustration of the thoughtful manner in which this important aspect of the problem was presented to the profession. It is said that "The phrase 'club practice' has been used as the equivalent of a system involving capitation payment, and the term 'private practice' as the equivalent of a system of payment per attendance. It is necessary to realize that the use of these phrases in this sense is misleading and that to the exact embodiment of the system the Association has found it necessary to take serious objections. Club practice, as hitherto known, has usually involved not only capitation payment, but also lay control and selection of special medical officers to carry on the work. Both of the latter elements have been declared by the Association to be, in its opinion, to a great extent, the cause of the under-payment of medical officers

*Of special interest in this connection is a statement made by the chairman at a meeting of the Manchester Insurance Committee on November 28, 1916, with reference to medical benefits. He refers to a letter by Dr. S. Colley Salter on the dissatisfaction of the public with the panel *system*, but not with the panel doctors.

and of other unsatisfactory conditions of existing systems of state practice. . . . The term 'private practice,' on the other hand, is inapplicable to any conceivable arrangement for the provision of medical attendance to a person who is insured against the cost of such attendance. The essence of private practice is the direct contract between the patient and the doctor, without the interference of any third party. But in any kind of medical service organized otherwise than by the profession itself, on the insurance or contributory basis, whether instituted in connection with state sickness insurance or by local authorities, or by Friendly Societies, the essence of the arrangement is the intervening of a third party which accepts the insurance risk and thereby becomes entitled to a voice in the arrangements. . . . In other words, that freedom of contract between doctor and patient which prevails in private practice is incompatible with the fundamental conditions of any medical service organized on any insurance basis."

Poor Law Aspects of Health Insurance

That the act does not meet the requirements of the necessitous poor is clearly brought out in a statement by Dr. N. Bishop Harman, at the British Medical Association's annual meeting, to the effect that fifty per cent. of the patients in the outdoor patient department were insurance cases. From another point of view, it may not be out of place to include some recent remarks of the grand master of the Manchester Unity of Odd Fellows, the foremost friendly society of Great Britain, with a membership of more than a million, who in his presidential address at the last annual conference, according to the *Western Mail*, dated May 25, 1920, is reported to have said that the "system of medical attendance had deteriorated under the blighting influence of state control, and that the socialization of the medical service would tend to a perfunctory and mercenary attitude and that it would destroy the professional pride and moral nobility of the physician's calling." It also said in this connection that while there may be a gain in material benefit, this is "at a sacrifice of the highest and the best." The outlook was therefore considered so serious by the grand master of this influential order that he frankly advised political pressure to bring about the required reforms.*

Evidence is also available to prove that the national health insurance act has fundamentally altered the relations of the general practitioner to the general public. For, as has been said by Mr. Joseph Smith, "the old friendly feeling which existed between the lodge and the doctor has gone." The relation has now become "a mere business transaction, and the prin-

*On the inclusion of poor law patients in a system of national health insurance, the Insurance Acts Committee in the Interim Report of 1916-1917 (D. 19, p. 3) remarks: "There remains a class of persons who normally might be expected to have been employed contributors, but who, usually owing to some physical, mental or moral imperfection, are not in receipt of an income and are provided with medical treatment through the Poor Law. It would be a great advantage from the point of view of unification of system and in other ways if these persons could share in the medical benefit of an insurance scheme, the 'parish doctor,' as such, being abolished, and the Guardians of the Poor being placed, as regards these persons, in the same position as the employer of the poorest class of low-wage earners."

cipal object of the medical profession seems to be not what can be done to relieve suffering or help the sick, but how much may be got out of the transaction in £ s. d."

Friendly Society Experience

The Nottinghamshire *Guardian* says editorially in this connection: "We are glad to see that at friendly society conferences that are now being held there have been strong complaints as to the working of the medical service under the National Insurance Act." For it is said: "When this Act was passed we were assured that it would provide an effective medical service for the whole people, and that as a result the public health would be greatly improved." But, it is pointed out, "the Act has now been in operation for some years and there has been plenty of time to test its working, but the results of the test are not good. *We do not think that any one is satisfied with the working of the Act.* The chief speakers at friendly society conferences this week regard the Act with aversion. They have no good thing to say about it. Insured persons who have to seek medical attendance from their panel doctors are very dissatisfied with the treatment they get. They affirm that the medical men do not investigate their cases with sufficient care, and that they are not permitted to prescribe expensive drugs even when the patients need them." In fact, it is said further, "Many insured persons when they are really ill consult another doctor and pay him. This is, generally speaking, a wise thing to do, for the panel doctors, on their part, say that the panel patients try to impose upon them. They demand medicines and attendance, we are told, when they are not ill and are rude if they do not get both promptly, and although medical men cannot afford to give up panel patients, they are very dissatisfied with the conditions under which these patients have to be treated. . . . It follows from this that the National Insurance Act must be drastically amended." This is said, regardless of the fact that most important changes have just been adopted by Parliament following a radical revision of the act in 1918. In truth, the changes have been so frequent and so numerous that *the man does not live who masters the whole of the legislation in all its details.*

Increased Contributions and Benefits

The recent amendment to the national health insurance act provides for increased contributions from 7d. per week to 10d. in the case of men and from 6d. to 9d. in the case of women. Cash benefits have been increased from 10s. per week to 15s. in the case of men and from 7s.6d. to 12s. in the case of women. Maternity benefit is increased from 30s. to 40s. in the case of a confinement. Other changes have been made which will materially increase the total cost of national health insurance, but remedy some of the most serious objections, including the claim of inadequate medical compensation. Heretofore medical men were paid at the

rate of 7s.3d. per capita, but this has recently been increased to 11s., although the demand of the British Medical Association was for 13s.6d. It is true that the difficulty was settled by arbitration, but there is widespread discontent with the agreement reached.*

Extension of Medical Service

An important question is usually overlooked in discussions of this kind, and that is the practical certainty of a very material increase in the demand upon a doctor's time under a liberal procedure of panel practice. It has, for illustration, been pointed out by Major S. T. Beggs, in the *Medical Officer* of April 24, 1920, "that over fifty per cent. of panel patients generally come annually under treatment and that in some districts the number attended may amount to as much as seventy-five per cent," but that "a greater proportion of the work will be for sickness of a minor character, entailing examination and certification during consulting hours." Ailments of the digestive and respiratory systems, catarrhal conditions and other minor complaints comprise the larger proportion of cases treated. The burden placed upon the general practitioner under such conditions easily exceeds the doctor's normal physical and mental capacity. As has been pointed out by Sir James Mackenzie in "The Future of Medicine," our present methods of diagnosis in incipient cases fall decidedly below proper requirements. This is largely because of the want of time and proper remuneration for exceptional services rendered. Instead of fostering a higher standard of medical practice, the panel system unquestionably lowers that standard to the point of standardized mediocrity.

The doctor, in brief, is reduced to a mechanical unit in a vast collective organization, largely directed and controlled by non-medical men and for non-medical purposes. The objective of any government organization is primarily conformity to statutory requirements. It is sometimes said that a government should adopt the methods of business procedure; but as a matter of fact and experience government exists primarily for other purposes than economy or efficiency in matters of detail, and in the nature of things this must be so, recalling the old saying that a government governs best which governs least. As observed in this connection by Mr. S. Sanderson, in his annual address at the National Association of Trade Union Approved Societies, February 3, 1920, "The great majority of people are inclined to say 'Let the State do it,' when any particularly complex and difficult task is to be performed. They regard the State as a glorified maid of all work. If only those who deal in difficulties in this

*In the House of Commons in May, 1911, Mr. Lloyd George placed on record the statement that he was done with contributions and that "There are no more contributions, not for management or anything." The increase in contributions recently adopted will by no means be the last. The additional benefits promised will have to be granted in course of time, including an adequate nursing and an adequate dental service, and the increased cost can be met only out of increased contributions, which, it may be expected, will fall most heavily upon industry, but also, in part, upon the wage-earners.

way would realize that the body whose aid they have invoked is not simply a collection of families or individuals without the right to interfere unduly with either, but, in the design of Providence, one possessing the duty of assisting them both to live full lives according to the measure of its potentialities and the resources at its disposal. We are all, I fear, apt to forget that the money to provide what are erroneously called 'Free State Benefits' does not spring from nowhere. Whatever is provided by the State has to be paid for in taxes, and nothing can be done by the State which is not paid for by the individual." These words of an experienced trade union representative should be taken to heart by those who would fatuously and enormously enlarge the sphere and the functions of the modern state.*

The Taint of "Cheapness"

In the report of the Insurance Acts Committee of 1916-1917 (D 19), it is said, "Many hold that the service is inadequate both in extent and in quality, and that it carries with it a taint of cheapness and semi-charity which should have no place in a system which was not provided for paupers, and for which the State is responsible." This view-point has been fully confirmed by my own personal inquiries and by an extended correspondence with panel practitioners throughout the United Kingdom.† Particularly suggestive is the frank admission on the part of the Insurance Acts Committee that "the replies show that the profession entirely agrees that the medical benefit is inadequate in extent; and they also show that there is still prevalent in some quarters the idea that the State system is a kind of 'club practice' in which the medical profession is being asked to give more than the State is paying for." This lamentable view-point unfortunately prevails widely and lies at the root of the continuous agitation for higher compensation, on either the panel or the attendance basis. This agitation is closely related to the controversy regarding the range of persons properly to be included within the provisions of a national health insurance act. Originally the limitation affected manual workers in the generally accepted sense of the term, or persons with an income of less than £160 per annum. In 1919, however, without extended consideration and much against the opposition of the British Medical Association, the income limit was raised to £250, further curtailing to that extent the possibilities or the range of private practice. In this respect the experience has practically been the same in the United Kingdom as in Germany, where the sphere of social insurance tends constantly to include a larger number of persons with comfortable incomes. Conversely no successful

*An exceptionally suggestive recent discussion of "Authority in the Modern State," is a small treatise with that title by the late Harold J. Laski (New Haven, 1919). Of particular value is the introductory chapter, including observations on the Limitations of Power, the Organization of Power and the Significance of Freedom. Of special importance is a chapter on Lamennais, illustrating the continuity of a virile philosophy to the present day. Quite useful also is the chapter on Administrative Syndicalism in France, with observations on the Right of Association, the Complaints of the Civil Service and the Movement Toward Reform.

†See pp. 77-82.

effort has been made to bring the poorer paid element of the population or the casual worker more successfully within the range of panel practice, largely because of the erroneous conception that the act is in truth an insurance measure when it is really and primarily a relief measure, modified in terms and phraseology to suit the needs of political expediency.*

Deposit Contributors

There has been a material improvement in national health insurance in the direction of simplification, which originally provided for twenty-three separate classes of insured persons. But the most important group of these classes, or the so-called "deposit contributors," continues to constitute a lamentable departure from all equity and justice, a group demanding prior consideration of its needs, as being most urgently in want of qualified medical assistance and financial support.†

Deposit contributors pay the same contributions as members of approved societies, but the contributions are paid in a special fund, and an individual account is kept of the sums paid in respect to each contributor, so that the payment of benefits depends in individual cases upon the amounts extending to his or her credit. It has been claimed by Mr. Horace B. Samuel that the position of the deposit contributor is clearly one of authentic insurance, but from what has been said it must be apparent that this is not the case. A concrete example, perhaps, will illustrate this point to advantage. According to the report of the Insurance Committee for the County of London, dated July 22, 1920, the number of deposit contributors making claims for sickness or disablement during the second half of the year 1919 was 3,200, equivalent to 3.7 per cent. of the membership. But the number of "claims in which benefits ceased by reason of depreciation of amount standing respectively to the credit of the insured person was 539, or 16.8 per cent. of the total number of cases dealt with during the period." During the previous six months, out of 4,480 cases dealt with, "the number of cases in which benefit ceased by reason of depreciation of the amounts standing respectively to the credit of the insured persons was 682, or 14.2 per cent.," but in addition in that period

*The German income limit has been materially increased since the close of the war and proposals have been introduced by the Socialistic party favoring a minimum income of 25,000 marks. If such a limit should be adopted, it would practically preclude private practice for all but a very small number of practitioners depending exclusively upon very wealthy clients.

†The position of the deposit contributor under compulsory insurance is perhaps the most convincing evidence of the persistence of rank injustice under class distinctions. It is practically true, as said in the Insurance supplement to the *New Statesman* of March 14, 1914, that "it is not only that these hundreds of thousands of contributors are taxed without getting personally hardly any of the advantages, but, what is more important, the community secures none of the protection against their subsequent indigence which it was the object of the scheme to afford." According to the report of the Manchester Insurance Committee of April 27, 1920, out of 13,580 deposit contributors 5,276 or 38.8 per cent. were not entitled to benefits. In the case of maternity benefit deposit contributors rarely receive the full amount of 30s. payable to ordinary contributors, or members of approved societies. According to a report of the Liverpool Insurance Committee, the average maternity benefit in 1918 was only 24s. 11d. Of the sickness and disablement payments in 1918, 187 were paid in full, while 86 were partial payments, no definite statement being made of those who were not entitled to any benefit whatever, it being not entirely clear whether suspension from benefit is equivalent to a complete denial of all benefit, since the suspension may be partial and not total. But during the year 1918 there were 6,931 cases of deposit contributors suspended from benefit, whereas the net number of deposit contributors in benefit on December 31, 1918, was only 4,005.

there were 328 cases "in which payment of benefit was withheld pending enquiries by the Commissioners, or in which information that payment had been made had not been received," and 1,122 cases "in which the insured persons were not qualified for benefit or where membership of an Approved Society was established, or where claims were not proceeded with." Calling attention only to the first class, those persons not receiving benefit because the individual amounts standing respectively to the credit of the claimants were exhausted, it is clearly apparent that the system is not one of insurance, but one of savings accumulation. Since the contributions paid are precisely the same as for members of Approved Societies, the position of the deposit contributor is clearly one of material disadvantage.

Since the statements are somewhat confusing on account of rules of office practice not readily understood without extended personal inquiry, it may be said that, according to another return, for the entire year 1919, out of 10,566 certificates for payment issued on account of sick benefit, the number of deposit contributors to whom "payment was not made, or ceased in consequence of exhaustion of credit," was 1,221, or 11.5 per cent. On account of maternity benefit, 1,725 certificates for payment were issued to deposit contributors, of which 227, or 13.2 per cent., were cases in which no payment was made or in which payment ceased in consequence of exhaustion of credit. Since the maternity benefit, according to the act, is 30s. in the event of a confinement, it is of interest to note that the 1,725 certificates for payment issued represented £2,155, whereas the amount which would have been paid had they been members of Approved Societies would have been 51,750 shillings. There was, therefore, in this group of cases a net loss of 8,650 shillings, on account of the fact that the members were deposit contributors, largely representative of the poorer and most needy element of the population.

Medical Controversies in Germany

The medical situation in Germany as the result of social insurance can not be referred to otherwise than one of chaos perilously near to disaster. At the annual meeting of the Associated German Sick Funds, held in the city of Leipzig on November 23 and 24, 1919, the subject was presented by Herr Lehman, who called attention to the demand that the lower limit of persons subject to compulsory insurance should be placed at M. 10,000, while the normal wages as a basis for the calculation of contributions should be increased from ten to twenty marks. The presiding officer, Herr Frassdorf, introduced his remarks with the suggestion that there was danger of converting sickness insurance into an insurance of doctors' income, and that there was great danger that more doctors would be employed than were necessary. He was in favor of salaried physicians precluded from the right of private practice. The much valued freedom of choice, he said, could not be granted, and the strongest opposition was

justified against the tendency of physicians to insist upon being paid for any and every service rendered. There was urgent need, he said, to adopt rules and regulations for the proper protection of funds against the wrongful demand of physicians. This was so much more called for in view of the fact that "medical attendance was frequently of a degrading and unprofessional character." If it were a question of survival, he said, it was much more important that the interests of the funds should receive consideration than the interests of the physicians. For the year 1920 the capitation fee was agreed to range between a minimum of twelve marks and a maximum of fifteen marks. This, he said, was the demand of the doctors, which could not be justified or granted. On an attendance basis, he said, domiciliary visits should be paid for at the rate of M. 2.50, and a maximum of M. 3.00, but office consultations should be paid for only at the rate of M. 2.00, while any special services should be on a basis of fifty per cent. additional to normal tariff charges approved by the government. On an average the number of calls to a case was given as 3.5 to 4.0, although, he implied, 3.5 was a liberal allowance; for he said it was well known that of the patients about forty per cent. required only a single consultation, while seventy per cent. required two consultations or less. He then enlarged upon the rules governing the compensation of rural practitioners and the mileage question. The distance traveled was required to be calculated in each and every case, but special conditions would be given special consideration. These rules conform very closely to the corresponding regulations of the British national health insurance. He makes the interesting observation, however, that rural physicians gave much more attention to the individual case than city physicians, which is also confirmed by investigations into the operation of the British system. He strongly objected to higher charges being paid for transfer patients or temporary visits. He concluded with some remarks concerning the medical attendance of dependents and the alleged unreasonable demands of physicians for such services. In view of the fact that only the insured are entitled to free medicine, the ratio of attendance on uninsured members of the family was much less. The care of other members of the family, he said, required about twenty per cent. of the total time of the physician.

The critical situation in Germany is illustrated in a report from the Munich *Medical Weekly* of May 28, 1920, according to which:

"At noon, May 25, all the contracts with the sickness insurance companies having expired, physicians all over the country were released from all contract obligations, and the Leipziger Verband, the solid front of the organized profession, has ordered that from that hour the krankenkassen insured are to be treated by the physicians as private patients, with cash payment at once for each service rendered. The fee to be asked is 8 marks for each office call and 12 marks for each visit, with specified higher rate for extra services. No certificates for the patients are to be made out, but

prescriptions are to be written on the physician's own blanks, and marked 'No renewal.' The *Wochenschrift* adds, 'These orders of the Leipziger Verband are to be unconditionally obeyed. On the strict and invariable compliance with them depends the outcome of the conflict into which the profession in Germany has now entered. Let no one think of his private advantage! The welfare of the whole is in the last line also what is best for the individual.' As pointed out in the *Journal* of the A. M. A., at the recent conference between the representatives of the organized profession and of the krankenkassen, when the former stated the tentative terms on which the contracts would be renewed, the representatives of the krankenkassen got up and left the room. The last mail brings word that a partial agreement has finally been reached between the parties, which is regarded as essential progress toward the desired 'free choice of physicians.' The krankenkassen have also agreed to found institutions to promote social hygiene. The question of remuneration is still unsettled and had to be left to a third impartial committee."

It has seemed advisable to include the foregoing within the present discussion, on account of the general inaccessibility of original German sources of information. It is no exaggeration to say that the present status of the German medical profession under social insurance is in every way a most deplorable one as regards the higher aims and ideals of medicine as a healing art.

Exempt Persons

The efforts which have been made to oppose the raising of the income limit have been as unsuccessful on the part of the medical profession as the efforts to improve the status of the deposit contributors. Equally complex and unsatisfactory is the position of the so-called "exempted" persons, or classes of employees who would otherwise be insured compulsorily, but "who are allowed, if they wish, to secure exemption, as persons in receipt of pensions or income of the annual value of £26 or upwards, or persons otherwise entitled to special consideration." In behalf of these persons the statutory contributions are required to be paid, although no benefits, broadly speaking, are received in return. There has also been a strong agitation in some sections for the inclusion of dependents within the scope and plan of national health insurance, as is the case under the German system. The inclusion of such dependents would of course enormously reduce the field of private practice and virtually constitute the panel system an almost exclusive state medical service.

The extension of certain benefits to dependents not making contributions has arisen most frequently in connection with the administration of sanatorium benefits. According to the last report from Scotland the procedure whereby, in the terms of section 17, of the principal act, the local authority and the treasury each contribute one-half of any deficiency arising

in the sanatorium benefit fund of an insurance committee which has extended the benefit to dependents of insured persons continues to be made use of in six county and nine burgh areas. In at least three other areas dependents are treated by the insurance committee, the ordinary sanatorium benefit fund being made applicable for the purpose.

This shows that the transaction is not one of insurance, but one of relief but slightly different from poor assistance under the poor law. It must have been a recognition of these facts that led to the decision on the part of the government to transfer the whole of the sanatorium benefit from national health insurance to the public authorities.

A Statement of Urgent Needs

To none of these elements does the state at the present time grant a medical service called for by modern requirements of health conservation as a prerequisite for the highest attainable degree of industrial efficiency. The agitation for extended benefits has been to small purpose, although a few important changes have been made. The extended benefits called for by the Insurance Acts Committee in its interim report of 1916-1917 included:

> *(i)* a consultant and specialist service; *(ii)* institutional treatment; *(iii)* pathological and clinical laboratory facilities; *(iv)* X-ray provision both for diagnosis and treatment; *(v)* special forms of treatment such as massage and electricity; *(vi)* dental treatment; *(vii)* a nursing service; *(viii)* advice with regard to pregnancy and attendance at confinement by a midwife with emergency attendance by a practitioner.

None of these benefits have as yet been conceded by the government regardless of countless alterations in minor provisions of the act, including the recent complete recasting of the scheme in the direction of higher cash benefits and increased contributions. The most important shortcomings of the present act include the want of all of the foregoing benefits, aside from others which cannot be enlarged upon at the present time; but it may be pointed out that the administration of anaesthetics in the case of even minor surgical operations is not provided for under the act, although it was readily conceded by the Insurance Acts Committee that this was "one variety of extra service which is at present in most frequent request and is on a most unsatisfactory footing." The committee repeat their earlier contention "that the administration of a general anaesthetic should not be considered to be included in the practitioner's contract, but should be added to the above list of services which should be provided as extra services." In taking this position the British Medical Association was clearly opposed to the best interest of the patient, resting its case upon the financial interest of the practitioner. The lamentable consequence of

the non-provision for anaesthetics can readily be conceived by any one familiar with the ordinary duties of a general practitioner.

The extension of benefits is perhaps the most pressing problem in national health insurance. Much will depend upon the forthcoming valuation as to what the policy of the approved societies is likely to be, but in a broader sense the public demand for an adequate medical service will not be made to rest upon the adequacy of the contributions heretofore paid or upon the favorable sickness expense yielding an available surplus from large benefits in one direction or another.

The view-point of the British medical profession is set forth in the following extract from the interim report on the Insurance Acts, D. 19, 1916-17:

"It is not necessary in this report to discuss the detailed methods by which these extra services should be provided, but there are certain points of a general character which should be insisted upon: (1) all these services would be outside the contract for ordinary domiciliary attendance and would necessitate special arrangements for the remuneration of practitioners rendering them; (2) general practitioners should be at liberty to give these services when qualified to do so; (3) at hospitals or special clinics the treatment should be given usually or exclusively on the recommendation of the practitioner in attendance on the patient, the work at these institutions being linked up with the domiciliary attendance in this way, and also by facilities being offered for qualified practitioners themselves to give institutional attendance, and by opportunities being afforded to all practitioners to maintain and extend their professional skill and experience by access to these institutions; (4) maternity hospitals should be available for all patients whose home conditions make confinement unusually dangerous, or who require at confinement operative interference of a major character."

Opposition to Consulting Clinics

Equally unsatisfactory is the explanation of the Insurance Acts Committee as to its opposition to the establishment of cooperative clinics or "centers where groups of practitioners would see all or most of their insured patients." Considering the strong tendency towards group medical practice in this country, as best emphasized in the world-wide recognition of the truly marvelous results of the Mayo Clinic of Rochester, Minnesota, this view-point of the British Medical Association cannot rest upon other than pecuniary, professional considerations.

It is said in this connection in the interim report of the Insurance Acts Committee that "cooperative clinics of a general character—that is, centres where groups of practitioners would see all or most of their insured patients—have been advocated. The objection to such an arrangement is that it necessarily, to some extent at least, detracts from the more intimate personal relationship between practitioner and patient which is fostered

when consultations take place only at the house of one or the other, and that thus insurance practice might tend to become more differentiated from ordinary family private practice than need be the case. It is probable, therefore, that it would be undesirable to establish such clinics as a universal or ordinary arrangement and as though they were necessarily good things in themselves; but there are undoubtedly neighborhoods of a poor industrial character, where the number of patients is large, where the supply of practitioners or of consulting room space is meagre and where this method of seeing patients would not differ materially from that already in vogue, in which the establishment of such clinics would be helpful to practitioners and patients alike until conditions alter. The inclusion of the dependents of insured persons for purposes of medical benefit would, of course, increase the desirability of these facilities in such localities."

This conclusion is diametrically opposed to the growing conviction in this country that group medicine is feasible and certain to result in far-reaching benefits.

A well-defined movement towards group medicine is this country dates from 1915, when the first consulting clinic was established on the Pacific coast. In a contribution to *Modern Medicine* of June, 1919, Dr. A. J. Barker Savage, Superintendent of the Broad Street Hospital, New York, has presented the essential facts of a plan of interdepartmental medicines in actual operation. The discussion has an admirable outline, based upon the experience which has been had at the Mayo Clinic.

In 1917 Dr. William Wallace Behlow, of San Francisco, in an address to the American Medical Association made a report on a group study of 150 cases based upon a diagnostic section of St. Lukes Hospital, San Francisco, and sustained by a statement in regard to follow-up letters illustrating the methods by which a diagnosis will prove the condition of cases reported, the results of recommendations regarding therapy and the impression of the attending physician concerning reports submitted to him.

There, of course, is the danger of overenthusiasm and of overspecialization, as emphasized in Sir James MacKenzie's lectures on the future of medicine; but, as has been said, "in the study of such cases a group has the advantage of being able to give a more rapid and more complete overhauling of the patient. Nevertheless, a large percentage of patients do not want and do not require such a thorough examination. It would seem ridiculous to put a man with a cut finger through such a process and expect him to pay for it as it would be to expect an automobile owner to have the entire machine overhauled each time he has a puncture." The tendency to carry the theory of group medicines to the extreme lies rather with the overenthusiastic layman than with the experienced members of the medical profession, but it may safely be asserted that the view-point is gaining ground in this country that group medicine or cooperative clinics offer the only satisfactory solution of certain very pressing questions in general medicine.

That this conviction is shared by many English practitioners as well as the government is clearly shown by the frequent and extended public discussions of the problems of medical organization or reorganization and the recently published interim report relative to medical and allied service.

It is suggested that this paper, generally known as the Dawson Report, contains not a single reference to national health insurance as a solution of the problems referred to the council for its consideration.

The English view-point may be considered as summarized in the editorial supplement to the *Lancet* of July 24, 1920: "At the present moment the great necessity for medical men is to take an all-round view of what is being done by the Ministry of Health for the national organization of medical service," and referring to the scant consideration of the Dawson Report, says "that it is considered, alike by the medical profession individually and through the British Medical Association, that the erection of Primary Health Centres is not only a pivotal part of the projected scheme, but a necessary development of the modern reading of preventive medicine in the larger sense—not the preventive medicine called hygiene, but that preventive medicine which forms the therapeutics of the future and which aims at arresting disease at its inception."

Limitation of Panel Lists

The same committee considered the question of the limitation of panel lists, giving expression to its strong opposition to such limitation in the words that "any limitation would, on the one hand restrict still further that choice of doctor by patient, which is essential, and might on the other hand result in an artificial curtailment of a practitioner's ability and energy."* Under the new rules and regulations the government has fixed the limitation of a panel at three thousand names, but in practice local insurance committees have adopted a much lower limit. No one seems to have seriously considered the question as to the ultimate outcome of the present system, which virtually provides that any physician entitled to practice in a given locality is of right also entitled to the assignment of a panel.

The fact, however, must first be taken into consideration that the panel system has very considerably increased the compensation of general practitioners previously finding it difficult to make more than a precarious living. The panel system, in other words, has raised the status of the inferior practitioner while decidedly discouraging the ambitious physician in private practice who places his sole reliance upon the public recognition of his exceptional skill. By raising the status of the inferior physician the attractions of general medical practice have necessarily increased, which may be accepted as an explanation of the large number of new medical

*This aspect of the problem has been discussed at some length by Dr. Thomas Gibson, in an address on "The Public Medical Service," contributed to *Public Health*, July, 1919, p. 112. See particularly Section I, on the "Free Choice of a Doctor."

students who will be graduated during the next few years and make demands for an assignment of panel practice, which necessarily must suggest a further limitation in the number of panel names. Assuming a community with an insured population of say 30,000 and a present panel of say 25 doctors, or an average of 1,200 names to a panel, it is self-evident that without reference to an increase in population an increase in the number of names on the panel can be brought about only by a panel limitation, which though beginning with three thousand names is certain in course of time to get as low as one thousand names, if private practice is to be allowed. The only other alternative is to raise the income limit and to bring a larger number of persons within the scope of national health insurance. This, however, will necessarily still further reduce the opportunities for private practice, which provides a considerable portion of the income of panel doctors.* When this point is reached there will be no alternative but to further raise the per capita rate of compensation, which may be said to have been increased from 4s. in the original calculations to 7s. 3d. at the close of the war and to 11s. at the present time. But it is the view-point of the British medical profession that this rate of compensation is far from adequate, and in the recent deliberations a maximum limit as high as 30s. per patient per annum was advanced, while the lowest limit was fixed at only 10s.†

The Facts of Panel Practice

The *Medical World* of August 8, 1919, contains an extended quotation from the London *Times* of July 29, illustrating the danger of large panels, and at the same time the growing opposition to the proposed limitation of panels of insured persons to 3,000. Reference is made to a conference of the British Medical Association as having "set its face sternly against discouragement of large panels by any lowering of the capitation fee, holding that such a suggestion of reduction on taking a quantity was derogatory to the responsible and honorable character of panel practice." The medical correspondent of the *Times*, however, takes occasion to point out that, "It does not seem to have occurred to the Conference that to take more work than can be properly performed may also be derogatory to panel practice," and he quotes in approval some remarks from the *Lancet*,

*The report of Sir William Plender, to the Chancellor of the Exchequer, on the result of his investigation into existing conditions in respect of medical attendance and remuneration in certain towns, was published in 1912, as a parliamentary paper (Cd. 6305), price 1d. This report, of which much is made, consists of six pages of superficial discussion far from representative of medical practice or sufficient as a basis for the momentous consequences involved in the establishment of national health insurance. Only 167 practitioners for 1910 and 171 practitioners for 1911 made reports, out of a total of certainly not less than 12,000 physicians originally enumerated on the panel. The returns were for six selected areas which cannot be considered representative of England, Wales and Scotland. The resulting conclusions gave an average income in towns of 5s. 6d. per capita in 1910 and of 5s. 7d. per capita in 1911. It is suggestive, however, since so much is made of bad debts or unpaid services in medical practice, that out of a gross income in 1911 of £113,908 only £6,824, or six per cent., was considered non-collectable. The report is a totally inadequate presentation of the information required not only in 1911 but as an underlying consideration in any question of readjustment of remuneration and terms.

†More recently a serious proposal has been made for a per capita fee of £1, which, of course, would add very considerably to the present expense of administering medical benefit.

that "No one, however, had a word of condonation for the single-handed practitioners alleged to have more than 6,000 patients on their lists." In conclusion, it is said that "there is no doubt that all chance of helping the progress of medicine will be lost if this panel system is perpetuated in its present form," for "where is the early detection of disease if the doctor —the detective—is rushing from door to door in an attempt to keep 6,000 persons on his list and draw 6,000 capitation fees? The thing is monstrous and an utter negation of progress. Let any reasonable man think what chance the early case of tuberculosis has of being recognised at this rate, or the early case of cancer. These too often must go on to death because there was not time for a prolonged and detailed examination." My personal investigations of panel practices fully substantiate this conclusion. I have been present in cases where the diagnosis was made of cancer and tuberculosis, though less than five minutes was given to the consultation. In Dr. Salter's evidence, quoted by Dr. Brend, the average time given to a consultation is 3.5 minutes, including the writing of the prescription and other incidentals! That probably ninety per cent., if not more, of all the physicians on the panel carry on private practice in addition to the estimated average of three-eighths of a practitioner's time being required for panel services can not, in my judgment, have a substantial foundation in actual experience unless the time allowance for individual consultations falls very materially short of the attention called for in private practice.

Of value in this connection is a letter contributed to the *Medical World* of August 15, 1919, on the proposed limitation of panel lists, illustrated by three cases, as follows:

"*A* lives in poor working class neighborhood, has about 4,000 on list, women and children not on panel attend "Babies' Welcome" and dispensary when ill. He has very little practice outside the panel, in fact, is practically a whole-time man.

"*B* in same district has 3,200 panel and 1,200 in children's club.

"*C* lives a little bit off—has 2,000 panel, 1,200 children's club and a fairly decent private practice.

"Of these three A has more time and it is more his interest to look after his panel patients than B or C. Yet some want to reduce his list and hand his patients to C. That gentleman may have £1,300 to £1,400 a year. If practices are to be restricted, then let it be done fairly all round, let no man be allowed to take more on his panel than what with other income from his practice, club and private work, shall bring his income to £1,150 per annum. It is ridiculous to say that a man who has nothing else to do can not look after 4,000 patients and yet state he can attend to 3,000 and later on, when women and children dependents are admitted, that he can have 1,500—2,000 women and children added on, as they probably were his patients. Such a statement I read in your paper. I sent a letter to the

B. M. A. something like the above, but they refused to print it. They are willing to curtail my list and rob me of £350 per annum but refuse to allow me to make a defence and show why it should not be done."

Considerations like these make it evident that the ultimate outcome must be a radical change in the view-point of the medical profession, which must of necessity become a fighting organization, or, in other words, enter politics to secure for itself the largest measure of adequate remuneration.*

The Federation of Medical and Allied Societies

It would carry me too far to deal with this question in detail, but a brief reference may be made to the recently organized Federation of Medical and Allied Societies and the Medico-Political Union, both of which strongly support a much more aggressive policy in opposition to the government than has heretofore prevailed in the British Medical Association. According to an account in the *Daily Telegraph* of January 24, 1920, a deputation from the British Federation of Medical and Allied Societies waited upon the Ministry of Health on January 23 to present its case for a thorough reconsideration of health insurance, suggesting a full investigation into the workings of the acts of 1911-1920. Dr. Arthur Latham took occasion to point out that the deputation desired to emphasize the fact "that national health insurance did not permit the insured person to receive all that the science of medicine had to give him and that under the regulations the panel practitioner was not able to do the effective work he was willing and anxious to do; or, in other words, that the insured public asked for bread, and were given a stone; *they asked for health, and were given regulations* which were chiefly designed to catch the erring doctor in some fault. For," he said further, "the tendency of the regulations was to impair the efficiency of the health service, and while there must be regulations, they were not to hamper efficiency, but should be elastic and be interpreted in the interests of the health services." Dr. Stancomb, of the Medico-Political Union, supported the suggestion for a public inquiry, and called attention to the "extraordinary and sordid concentration of a large body of men on the financial and economic side of the profession. "This," he said, "was due to the fact that under the regulations and restrictions of the national insurance act they had very little else to be interested in. The better instincts of the profession were not sufficiently aroused, since the question of remuneration was not directly related to the question of medical efficiency."

Demand for a Parliamentary Inquiry

Dr. Addison, the Minister of Health, frankly conceded the lamentable chaos of the present-day health service which he had himself condemned on many occasions and he shared their misgivings as to the unsatisfactory character of much of the present work. With reference to the demand for

*Of exceptional interest are the proceedings of the Medico-Political Union, and the extended discussions of every controversial aspect of the medical side of national health insurance, in the *Medical World*, its official organ. (14 Gray's Inn Square, London, W.C.1.)

a public inquiry, Dr. Addison said he was "not opposed to such an inquiry if it should prove to be the best way of instructing the public and the medical profession. He had the authority of the Cabinet for saying that they held themselves free to institute a wider inquiry if it should be found desirable or necessary, either as a result of the findings of the arbitrators or of the report of the Consultative Council." No such inquiry has been authorized or is likely to be made through the initiative of the government. But as will subsequently be pointed out, an important report has been forthcoming from Lord Dawson, of Penn, as chairman of the Consultative Council, suggestive of far-reaching reforms in general health administration, necessarily bearing upon the more restricted problem of the status of medical practitioners under national health insurance.*

Medical Referees

The proposed reforms are clearly tending towards a public medical service in the broader sense of the term. Even at the present time an immense staff of physicians is employed by the government in public medical services on the poor law medical staff, pension boards, etc., forming the nucleus of a medical civil service which it may safely be assumed will in course of time be materially enlarged and possibly become universal. The proposed employment of state-paid referees or whole-time medical practitioners for the purpose of ascertaining fitness for work in possible cases of malingering is but one more step in this direction. Of some importance in this connection are the increasing demands of the government upon panel practitioners for certificates and records which necessarily consume much time and labor if the duties are properly performed. It was made a part of the original understanding that in return for a specified consideration the medical practitioner should render a proper report upon each and every case under treatment, but this requirement was set aside during the war for obvious reasons of national economy. Without such records, however, the government will be entirely wanting in the necessary evidence of local health injurious conditions which underlie the provision of the law which holds the locality in part responsible for a possible excess in local sickness experience. Waiving the question whether such inquiries can be made with the required impartiality and scientific thoroughness, it may be said that in the judgment of Dr. Brend and others the cost of such investigations, made primarily for financial purposes, will be practically prohibitive.

The employment of medical referees is a recognized necessity as a safeguard against malingering and fraud. The term "malingering" in national health insurance has a different meaning than in workmen's compensation, where injuries are frequently alleged to have been sustained in the course of a fortuitous event although strictly attributable

*See p. 112 *et seq.*, and Interim Report on the Future Provisions of Medical and Allied Services, published as a Parliamentary Paper (Cmd. 693), London, 1920, price 1s.; also First Report of the Welsh Consultative Council (Cmd. 703), London, 1920.

to some preexisting disease. In national health insurance the problem is not so much one of alleged obscure ailments as of undue prolongation of the original illness into one of extended duration for pecuniary gain. That such prolongation is the rule rather than the exception is clearly brought out by the numerous investigations of medical referees employed jointly by insurance committees and approved societies. To eliminate the possible bias on the part of such referees it is now proposed to have the work carried on exclusively as a state function. The practical difficulty rests upon the ill-advised conception as to what constitutes a patient's fitness for work. *The sickness benefit is not paid on account of the illness of the patient but on account of his inability to work or earn a living.* The employment of state medical referees has the sanction of the British Medical Association, which in its interim report for 1916-1917, among other recommendations, laid down the principle that medical referees "should be well paid by a salary independent of the medical benefit fund." It may not be out of place on this occasion to draw attention to the decidedly higher standards of state medical compensation in Great Britain than in the United States. For purposes of contrast it may be said that, according to the *British Medical Journal* (May 22, 1920), "No advertisement is at present accepted by the *British Medical Journal*, the *Lancet*, or the *Medical Officer*, for an assistant medical officer of health, assistant school medical officer, assistant tuberculosis officer, or other similar post, at a salary less than £500 per annum, exclusive of all traveling and office expenses." This salary would be equivalent, approximately, to $2,500 per annum, which is but $500 less than the salary paid to the chief medical officer of the Indian Service by the federal government, the general staff of the Service receiving salaries from a minimum of about $800 to a maximum of but $1,800 per annum! Considering the much more responsible position and under given conditions the strenuous services required in view of the vast areas of territory to be gone over and the more exacting demands upon the doctor's time, it is self-evident that the compensation paid to medical practitioners in our Indian Service at the present time falls far below the compensation accepted as a minimum by subordinates in the public medical service of Great Britain.* If the inadequate compensation paid to medical officers in the public medical service of our Indian wards is to be accepted as an illustration of what is likely to be the case in the future, it is self-evident that the status of the general practitioner will under a system of compulsory health insurance be perceptibly lowered instead of being raised.†

*For a brief discussion of the lamentable situation in our Indian Medical Service, calling for drastic changes, see my letter in the Journal of the American Medical Association, August 14, 1920, pp. 493-494.

†Under the amended act of 1920 the Ministry of Health has recently appointed thirty-two referee consultants at £1,000 a year, "with the object of protecting insurance funds from unnecessary claims for sickness benefit and improving the general standard of insurance medical practice." Originally, a Parliamentary appropriation had been made for this purpose in 1914, but nothing was done on account of the impossibility of establishing this extension of the medical service during the war. (See, also, Report for 1914-1917, pp. 80-81.)

Conditions of Rural Practice

The question involved bears directly upon perhaps the most important aspect of the larger problem, and that is the status of the rural practitioner. It has been pointed out in a recent editorial of the Denver *Times* (June 3, 1920), that the number of rural practitioners is relatively diminishing while the proportion of doctors in towns and cities is increasing, and a prominent medical journal is authority for the statement that the country doctors are moving to town at a really alarming rate, "many of the smaller communities that formerly were homes of physicians with large and lucrative practices are now without the services of a medical practitioner." The situation in England is equally difficult and made more so by the panel system. According to the report of the Insurance Acts Committee, the opinion is widely held by rural practitioners that they are unfairly remunerated as compared with urban practitioners, and the recommendation was therefore made and subsequently approved for a material increase in the so-called mileage grants or allowance for traveling expenses and the division of the local pool or amount available for compensation "among practitioners upon the basis of the number of insured persons upon each practitioner's list who are resident from two to three miles from the practitioner's residence; the payment being made in respect of each mile or part of a mile over two miles."*

Mileage Grant and Practice Expenses

The foregoing provision is typical of the German system and its true significance can only be understood after a thorough investigation of actual procedure. The rules and regulations governing the distribution of the new mileage fund, which will amount to £300,000 per annum, are not yet available, but the principle of measuring the rate of compensation in proportion to the distance of the patient's residence from the doctor's office will no doubt be continued. This virtually makes it necessary for a physician to determine in each and every case the precise distance of a patient from his office, which must frequently involve serious difficulties; in fact, this has been clearly recognized and minute regulations have been proposed for the safeguarding of the interests of both the doctors and the government. A practical illustration will make the foregoing point clear. According to the annual report of the Insurance Committee of Carnarvonshire, Wales, the sum of £580 was divisible among forty-four rural practitioners. These reported 5,912 miles traveled on satisfactory roads, for which they were paid an allowance of 11½d. per mile, or £283; 1,064 miles were traveled over heavy roads, for which the compensation was at the rate of 1s.6d. per mile, amounting to nearly £80; 1,682

*Among other suggestive reports containing much valuable information are the "Scheme Adopted by the Insurance Committee for the Burgh of Aberdeen," 1918, and the "Report of the Medical Service Sub-Committee on the Referee Scheme of the Aberdeen Burgh Insurance Committee," for 1918; also a "Report on the Operation of the Medical Referee Scheme for the Years 1917-1918," of the Insurance Committee of the County of Ayr, Scotland.

miles were traveled over roads difficult of access, paid for at the rate of 2s.6d. per mile, or £210; while, finally, on account of travel to 159 "abnormal places" the allowance was 10d. per insured person, or £6 12s. 6d. Since the total mileage grant available was £823 12s., there remained a balance of £243 12s., which was distributed pro rata among the claimants.*

The foregoing calculations are merely with reference to the condition of the roads traveled and do not bear upon the equally involved question as to the distance of the patient from the doctor's office; but the illustration will sufficiently emphasize the extremely burdensome nature of a system typically German, if, in fact, the rules and regulations have not been literally translated from preexisting German laws or ordinances.†

Temporary Residents

The complications of panel practice have increased rather than decreased with the development of the system. One of the most important questions is the proper treatment of temporary residents or visitors whose domicile is in some other locality where the patient is duly registered with the local panel physician. In other words, a person insured in one locality may claim the right of panel treatment in another locality from any physician on the panel in accordance with the choice of the patient. The compensation for such cases is involved and disputes and difficulties are a matter of common occurrence. The recommendations of the Insurance Acts Committee on this point are that *(a)* each quarter the practitioner should notify, by signing Part C of the medical card and sending it in to the Insurance Committee, the names of temporary residents actually attended; and *(b)* for the purpose of determining his proportion of the area pool an appropriate addition would be made for his remuneration for the ensuing quarter in respect of persons so notified; and this addition might be made by counting a smaller number of temporary residents as equivalent to a larger number of ordinary insured persons, or, respectively, three as five, or two as three, or one as two, as might be agreed

*The following statement is from the proceedings of the annual meeting of the British Medical Association, 1920, as reported in the *British Medical Journal,* of July 10, 1920:

"The Ministry of Health has issued a circular to Insurance Committees dealing with the Central Mileage Fund for 1920, and authorizing Insurance Committees to make advance payments to practitioners in respect of mileage for the current year. It is important that practitioners should understand that the present advances relate solely to claims based upon distance, and do not attempt to cover districts of exceptional difficulty. Unless this is carefully noted, doctors living in such districts will be inclined to believe that the cheques they receive are unduly small. The circular of the Ministry makes it clear that the allotment to districts of exceptional difficulty can only be made after fuller information has been received. The information which has been sent in to the Ministry is far from being as complete as it should be, and in accordance with the promise previously given by the Ministry payments will only be made in respect of mileage to those doctors who have supplied the Insurance Committee with particulars of the insured persons on their lists." Such illustrations but inadequately convey a clear statement of the facts of a situation which is becoming more confused as new regulations are made public from time to time with reference to an increasing amount of detail.

†Among other publications the following should be consulte l as suggestive of the sources of English rules and regulations as probably derived from German pharmaceutical practice: "Die Arzneiversorgung in den Krankenkassen und deren Kontrolle," Dr. Wilhelm Remmer, Vertrauensarzt, der Gemeinsamen Ortskrankenkasse Strassburg, 1910; "Handverkaufs-Taxe fur die Allgemeine Ortskrankenkasse Strassburg Stadt," Strassburg, 1915; "Richtlinien fur die Arzneiverordnung bei den Bremischen Krankenkassen," Bremen, 1919.

upon. The facts require only to be stated to illustrate the extreme difficulty of a proper and satisfactory settlement to all concerned. Obviously the only ultimate solution will be a universal public medical service, subject possibly to restrictions as to those who would and those who would not be entitled thereto.

Disputes and Controversies

Under the changed conditions neither the panel patient nor the panel physician can claim to be free agents, both being subject in all of their actions to the necessary rules and regulations of the insurance commissioners of the Ministry of Health. The numerous committees, or, respectively, the insurance committees, the medical committees, panel (doctors) committees and chemists (druggists) committees, all perform like and unlike functions, more or less in conflict with each other. All are time-consuming and frequently very much so in cases of prolonged controversies over matters which have no concern with the practice of medicine as a healing art. The maintenance of proper standards of efficiency in medical service, in the supply of drugs and in the relation of the panel practitioner to the local sanitary administration must needs lead to disputes which affect, respectively, the doctors, the chemists and the insured person, occasionally with results disastrous to all concerned.

Cases of removal from the panel are naturally of most serious concern, since to be deprived of a panel practice means practically, in many cases, to be deprived of the opportunity of earning a living. The *Lancet*, under date of March 20, 1920, reports the case of a panel doctor's action for slander (p. 676), in which a Dr. James Wylie brought an action against the general secretary of a local friendly society on account of a dispute concerning a certificate of incapacity given by the doctor on a date when it was understood, erroneously, by the secretary that the patient was still away from home. According to the *Lancet* account, "the secretary thereupon stated in a letter to the Insurance Committee that a certificate had been granted by the doctor without seeing the patient and in contravention of the law." In the course of the proceedings it was claimed that the secretary's letter was defamatory and malicious, and damages were awarded to the doctor. On the sheriff's appeal this decision was reversed on the ground that the "occasion of writing the letter was privileged, and that malice had not been proved." On appeal, however, the first judgment was upheld on the ground that "the letter had been sent without due inquiry, and that the defender's recklessness in making the charge, without regard to its serious nature and to the want of information on which it was founded, amounted to legal malice, disentitling the defender to plead privilege." The action was brought by the Medical and Dental Defense Union of Scotland, which is congratulated by the *Lancet* on its successful vindication of the good name of the panel doctor. But in many other cases doctors have been found guilty and punished with

heavy damages for failure to conform to the countless rules and regulations which, as illustrated in the present case, involve a practically constant risk of controversy on the part of the physician in his relation to the public.

The Right of Appeal

From a medical point of view there is perhaps no more important aspect of national health insurance than the security of the doctor's status on the panel. As pointed out in the *British Medical Journal*, of May 22, 1920, in referring to the insurance practitioner's right of appeal to the High Court, it was resolved on November, 1919, at the panel conference that any person aggrieved by the removal of his name from the list may, within three months after the date on which notice is given to him by the Minister that his name has been so removed, appeal to the High Court, and on any such appeal the High Court may give such directions in the matter as it thinks proper, including directions as to the costs of the appeal, and the order of the High Court shall be final and conclusive, and not subject to an appeal to any other court.

Since the procedure generally adopted is not widely known, the *Lancet* of May 29, 1920, reprinted a letter which presents the official viewpoint of the Ministry of Health and which as a matter of record is given in full as follows:

"Ministry of Health, 19th May, 1920.

"Barchester Insurance Committee and Dr. A. B. C.

"Sir:—I am directed by the Minister of Health to enclose a copy of the report made by the Inquiry Committee appointed to consider the representations made by your clients, the Barchester Insurance Committee, against Dr. A. B. C., and to state that, in view of the findings contained in the report, the Minister is not satisfied that the continuance of Dr. A. B. C. on the panel would be prejudicial to the efficiency of the medical service of insured persons, and he has accordingly decided to take no further action in the matter.

"In view, however, of the breaches of the Medical Certification Rules disclosed in the report, the Minister would have been disposed to inflict a monetary penalty on Dr. A. B. C. by means of withholding Exchequer grant from the Committee, had the Committee recommended this action in the first instance; and for this reason he does not propose to make an order with regard to the costs of the inquiry.

"I am, Sir, your obedient servant.

"(Signed) R. H. Crooke,

"The Solicitor to the Barchester Insurance Committee."

The foregoing case is not an isolated instance but typical of a situation which cannot but be considered otherwise than as threatening the professional status of the physician. An important controversy has recently

arisen in parliamentary discussions of amendments to the national health insurance acts, perhaps best illustrated in a statement made in a communication dated April 17, 1920, from Dr. Adam Fox, of Stalybridge, to the British Medical Association, which presents the position of the panel practitioner with regard to the right of appeal to the High Court, as follows:

"The Insurance Act of 1911 placed panel practitioners *unreservedly* in the power of the Commissioners, from whose decisions no appeal could be made to the High Court. The judges of the High Court could only hear a case if the Commissioners exceeded their jurisdiction, or, in other words, acted *ultra vires,* or if the procedure had not been correctly carried out. The Commissioners, could, however, at any time introduce new Regulations, and which, if placed upon the table of the House of Commons for a brief period, became then, as it were, a part of the Act. In this way the Commissioners could very quickly convert points which were *ultra vires* into *intra vires,* and in this way panel men have been cut off from the High Court."

As observed by Dr. Fox, the principle here disclosed is fundamentally unsound and unconstitutional, in that it contravenes the inherent right of every citizen to the courts of law, as the only real safeguard of freedom of action and individual liberty, which a citizen posesses, but the powers of the commissioners are now vested in the Minister of Health, who, as Dr. Fox points out, "has thus become an absolute autocrat where panel men are concerned."*

In the consideration of the national health insurance bill in the House of Commons, May 14, 1920, a new clause was moved, providing that:

"(1) Any medical practitioner aggrieved by a decision of the Minister, or of any special body through which the powers and duties of the Minister, under Section 15, Subsection (2) (b), of the Act of 1911, are exercised, to remove his name from any list of medical practitioners, may appeal against the decision to the High Court, within the time, and in the manner, and on the conditions directed by the rules of the court. (2) The cost of any such appeal shall be in the discretion of the court, and no appeal shall be allowed from any order or decision of the court in any such appeal."

In moving this clause, Captain Elliot explained that it would restore a right which had been taken away from the medical profession under the

*For a lucid illustration of parliamentary procedure and its wide divergence from American methods of popular law-making, see "Parliament and Revolution," by Ramsay McDonald, New York, 1920, p. 159 *et seq.*

original act of 1911. All the right to appeal at the present time, he said, was with the Minister of Health, moreover that "if a medical practitioner was struck off the panel he was debarred from the treatment of what was already a majority of the population of the kingdom, and what would, if the dependents were brought within the scheme of the Act, become an overwhelming majority of the people. The medical profession did not consider it was fair that the bureaucracy should have this tremendous power over a medical practitioner, on the ground, first that it would lead to *a stereotyping of medical practice.* Nobody would risk embarking on some individual line of treatment if he knew that any failure of that treatment would be brought before a committee of what were after all his trade competitors. In this case the bureaucracy was extending its power over the ordinary surgeon. A man who had the right to enroll his name on the panel of doctors should not have his name removed without at least a chance to appeal to the courts of law."

After seconding this new clause, Lieutenant-Colonel Freemantle took occasion to say that there was a tendency of certain members of the profession to say "We will have nothing to do with this panel practice." This, of course, was a bad condition for any government service to get into. While he held a high opinion of his profession and of the Minister of Health, who was the judge in this matter, he thought it was wrong that medical men should be judged in a matter like this by such a court as was suggested. The Minister of Health, who was present, took exception to the statement made, holding that the bill in its original form did not propose an extension of power over the medical practitioners. After much further discussion the clause was adopted. I make reference to this discussion not so much as regards the merits of the controversy as to emphasize the conflict of view-point of men thoroughly familiar with the status of a highly specialized profession in its relation to the government. Such controversies can only result in a growing discontent and failure to raise the standard of what is as yet far from being a thoroughly satisfactory service.

The Question of Adequate Remuneration

Such controversies, however, affect, after all, but a small proportion of the physicians on the panel, while the larger question of adequate remuneration concerns the whole panel service. There are two questions involved here which, generally speaking, have received totally inadequate consideration, and that is, first, the actual remuneration earned, according to the number of patients treated during the year, and, second, the actual payments made to panel doctors out of the pool available for distribution. It is claimed, for illustration, that the average payment per case treated is less than 2s. per office attendance, and less than 2s. 6d. for a home visit. It is not generally known that while the per capita system prevails throughout the United Kingdom, there is one notable exception in the

case of the city of Manchester, where the payment of physicians is on an attendance basis.*

Payment by Attendance

The Manchester method is perhaps the most illuminating contribution to actual experience under national health insurance, for while the payment of physicians is on a different basis, the total amounts paid out are precisely the same as would be the case under the per capita system. I therefore include the following statement of the Manchester medical experience for the year 1917, which has kindly been placed at my disposal by the Manchester Insurance Committee. The number of patients treated during the year 1917 was 250,963, and the number of services rendered was 4.1; or, in other words, each patient required on an average about four calls, either at the surgeon's office or at the patient's home.† The total result is represented by 1,019,354 services, distributed according to their nature as follows:

Manchester Insurance Committee Medical Service, 1917

Kind of Service	Rate Charged	Number of Services	Per Cent.
Office attendances	2s.	863,532	84.7
Home visits	2s. 6d.	152,342	14.94
Special visits	3s. 6d.	2,411	.24
Night visits	5s.	818	.08
Operations	10s. 6d.	133	.013
Fractures	10s. 6d.	82	.008
Amputations	21s.	20	.002
Dislocations	10s. 6d.	16	.002
		1,019,354	100.00

The Manchester Experience

This table represents the total medical activities under national health insurance for an insured population of approximately 250,000. On account of the 1,019,354 services there was a theoretical charge on the basis of the fee schedule as included in the table of £106,164, or an average charge of 2s. 1d. per service, and of 8s. 6d. per patient. The average income per patient varied from 8s. 1d. during the September quarter to 8s. 9d. during the March quarter. But these theoretical charges were reduced by the panel committee considering the individual accounts of physicians in the manner that, for illustration, for the last quarter of the year the theoretical or claim charge per patient was reduced from 8s. 8d. to 8s. 6d. These reductions which are made to conform to the actual payments under the amount available for distribution reduced the

*For an extended discussion of the early view-point regarding medical remuneration, see report of the Organization of Medical Attendence, *British Medical Journal* of March 4, 1911, pages 98-106.

†For a full discussion of the methods of payments of attendence see *British Medical Journal* of March 4, 1911, pages 100-105.

claimed amount of fees, as previously given, from £106,164 to £98,914. This, however, by no means represented the actual amount paid to physicians in charge, which was further reduced by the Insurance Committee in the final settlement of the accounts to £90,411. Hence on the basis of 250,963 patients treated during the year 1917, it appears that doctors claimed £106,164, or 8s. 6d. per patient; that the panel committee agreed to a payment of £98,914, or 7s. 11d. per patient; whereas the actual payment approved by the Insurance Committee was £90,411, or 7s. 2d. per patient. There could be no more illuminating illustration of the complexities of the present system, which it is safe to say, however, is as simple as the circumstances permit, once the principle of state interference in medical treatment on a *quasi* insurance basis is granted.

The Manchester medical experience of 1917 under national health insurance represents fairly normal conditions. It would be quite out of the question to present all the details of this experience, but it is only on the basis of a complete analysis of what is actually taking place that sound conclusions can be based for or against the practical utility of such a complete revolution in the relations of a vast professional service to the public. The following illustration will, however, serve the present purpose of making the facts as readily understood as is possible. The account of Dr. H. J. is before me. During the quarter ending March 31, 1920, he rendered 364 services, of which 287 were office attendances, fifty-eight domiciliary visits, eleven special visits, six night visits, one surgical operation and one amputation. The number of patients represented by the 364 services was fifty-nine. On account of these the doctor charged £40 19s., or an average of 13s 11d. per patient. The panel committee allowed, however, only a standard average rate of 8s. per patient, giving the doctor credit for £23 12s. actually assigned. But, the amount thus assigned, given as £23 12s., was further reduced by the Insurance Committee to £15 6s. 6d., as against £40 19s. originally claimed! Under conditions like these a satisfactory medical service must necessarily become extremely difficult, for not only does the doctor feel that he is inadequately paid and that his remuneration depends upon the more or less arbitrary action of others, but he is confronted by the uncertainty of being able to tell at any given time what his income really is or is likely to be. (See Appendix H.)

Conflicting Statistical Records

The compensation question would seem to admit of no satisfactory solution without radical changes in the fundamental methods of administering the act. It has properly been said in a letter by Dr. Philip L. Benson, contributed to the *British Medical Journal* of December 27, 1919, that "every poor little village club in the old days could pay to the uttermost farthing what they agreed to pay, while the powerful government department cannot do so because, forsooth, they cannot keep a proper list of

those who are on the doctor's panel." Inflated lists are the rule rather than the exception, and inflation necessarily means compensation not earned when the payment is on the capitation basis or of the names assigned to a doctor, though the parties may long since have moved out of the community, or be out of employment, or not entitled to benefit, or unwilling to make use thereof, or, as not infrequently happens, are actually dead and buried!

Every life insurance company knows with absolute certainty whether a policy is in force or not, whereas the British government has completely failed in establishing a system of record-keeping which infallibly yields results mutually satisfactory to the insured, the medical profession and the state.

Conflicting Medical Registers

It would be quite out of the question to more than very briefly discuss the important problem of inflated lists, but it may be said that from the view-point of adequate compensation it is clearly recognized that the present system fails most seriously in this particular direction. In a report made to the Glasgow Insurance Committee under date of March 21, 1917, on "Differences in Numbers of Insured Persons on Index and Medical Registers and Numbers Credited for by the Insurance Commissioners," the clerk of the committee, Mr. William Jones, takes occasion to say:

"That Insurance Committees' Index and Medical Registers are inflated is generally recognized, and certain figures furnished by the Insurance Commissioners to the British Medical Association indicated the extent of the inflation, with an explanation of some of the causes thereof. The principle cause of inflation at present is, of course, the delay in the notification to societies, and by them to committees, of suspensions from medical benefit following on enlistments, while there is also delay in notifying the withdrawal from registers of persons who may cease to be entitled to medical benefit for various reasons, *e. g.*, suspension because of arrears of contributions, ceasing to be insured on marriage, or on passing beyond the insured rate of remuneration, emigrations, deaths, etc. These failures to notify change in status in regard to insurance result in names being retained in the Index and Medical Registers of Committees for periods long after credit has ceased to accrue in respect of the persons, and many names may in fact be removed only when, in the ordinary course, the person is suspended from benefits by the operation of the Arrears Regulations."

I have given this extract in full as a practical illustration of the difficulty of thoroughly understanding the intricacies of a system which must necessarily be of the essence of bureaucracy if the state is to be adequately protected against the ever-present risk of errors, malingering and fraud.

It is pointed out in this connection by Mr. Jones that with a view to measuring, in some degree, the extent of the inflation of the registers for the Glasgow area, he caused special records to be kept of late notifications of suspensions from medical benefit, with the following result:

"The amount finally credited by the Commissioners to the committee for purposes of medical benefit for the year 1915 was £137,519 16s. This amount applies both to medical treatment and to drugs, and includes the proportion of Government grants payable to the committee. It excludes, however, the amount transferred from Sanatorium Benefit Fund Account in respect of the domiciliary treatment of tuberculosis. The committee is entitled to a total capitation fee for medical benefit purposes of 8s. 6d. *per insured person per annum.* Dividing the total fund, therefore, by the capitation fee, there results the number of 323,576, which is to be regarded as the *average daily number* of persons on the committee's Registers throughout the year 1915, in respect of whom the committee have been credited with a capitation fee."

On the basis of this preliminary investigation the conclusion was arrived at that in comparison with the number credited the mean number of persons on the register of the committee entitled to medical benefit during the year was 409,942, or an excess of 86,366, or 26.7 per cent. Such a degree of error would be utterly inconceivable in the management of an industrial or ordinary insurance company transacting business in conformity to the statutory requirements of American states. Making all allowance for errors resulting due to enlistments, the minimum margin is placed at sixteen per cent.!

Improvement in Statistical Practice

In brief, there exists an apparently hopeless confusion between the results shown by the medical register of persons entitled to benefit and those on the index registers of the local practitioners, which represents the names of persons certified to by approved societies as entitled to medical benefit. It is not likely that the difference would be less serious in this country than in England, where a trained body of civil servants with large experience in sound methods of public administration are charged with the responsible duty of efficient office control.

The best evidence of an earnest effort to bring order out of chaos is an address on "Index Registers" by Mr. C. W. Followes, read at the annual meeting of the National Associations of Clerks to Insurance Committees, May, 1916, and an elaborate "Index Register" by Mr. Thomas S. Herron, of the Wishaw Insurance Committee, issued in 1919. This manual clearly emphasizes the extremely complex character of the office transactions concerning the security of the person entitled to medical benefit

on the one hand and the adequate protection of the panel physician against imposition and negligence on the other.*

Lapses and Suspensions in Health Insurance

In this connection a brief reference may be made to the frequent assertion that there are no lapses under national health insurance. As a matter of fact, the rules and regulations governing suspension from benefit in the event of the non-payment of contributions are much more complicated than in the case of industrial insurance.† The best practical illustration is the considerable proportion of deposit contributors who are continually out of benefit. For example, during the second quarter of the year 1919, the total number of deposit contributors on the register of the Manchester Insurance Committee was 12,187, but of this number, 4,705, or 38.6 per cent., were not entitled to full benefit; in other words, the element most urgently in need of the benefits of national health insurance is most likely to be deprived thereof because of suspension under the rules. (Year Book for 1919, Manchester Insurance Committee, pp. 58-61.)

Assumed and Actual Earnings

The preceding observations with reference to the index registers explain in part the wide divergence of views as regards the actual earnings of medical practitioners under national health insurance in proportion to the services rendered. Through the exceptional courtesy of a practising panel physician in the south of England I have been provided with a return of his experience for 1913 to 1918, according to which the average remuneration worked out at the rate of 1s. 4d. per office attendance and 2s. 6d. per home visit. In 1918 the average number of attendances per patient was 7.3; the ratio of office attendances to home visits was as 10 to 1. According to the evidence included in the Special Conference Report of representatives of local and panel committees, July, 1919, the

*See article on Index Registers and Clearance Procedure by C. M. Watts, Esq., in the Journal of the National Association of Insurance Clerks for August, 1920, page 170.

†The question of suspension of benefits when contributions are in arrears is too complicated to admit of discussion on this occasion. Under normal conditions of employment difficulties are not likely to be serious, since, of course, the deduction of the contributions from wages is both compulsory and automatic. Section 10 of the original act reads, "Where an insured person, a member of an Approved Society is in arrears with his weekly contributions to the extent therein specified he shall be liable to a reduction, postponement or suspension from benefit, etc." The penalties vary with the number of contributions due but unpaid. The rules vary according to the different benefits, whether medical, sanatorium, disablement or sickness, and it will be sufficient for the present purpose to say that under the original act the right to medical benefit was not suspended until the insured person was in arrears for more than twenty-six weeks' contributions a year or a longer period. This would imply that the payments are looked upon in a cumulative sense and that extended calculations are required in each and every case to determine the rights and duties of the insured. Every insurance committee keeps a suspense account, based upon the suspense slips, in practically the same manner as lapse cards are kept by insurance companies. No trustworthy information on a sufficient scale has been made public to show the proportion of persons suspended from any one or all of the benefits under the acts, on account of the non-payment of contributions, but practically every member of an approved society has in this respect a decided advantage over a deposit contributor. Suspense slips have reference to cases of insured persons entitled to all benefits but for whom the insurance committee are unable to trace approximate index slips. Orange slips have reference exclusively to persons suspended from or disentitled to benefits, irrespective of whether insured with approved societies or deposit contributors. This is the official designation given by the Manchester Insurance Committee, which at the same time supplies a table for the year 1917-1918 of index slips of all kinds, indicating that on October 1, 1918, the number of orange slips was 130,035, out of a total number of 435,847 slips. A slip, in other words, represents a member, whether entitled to benefit or not, and the foregoing would therefore seem to indicate that of the total membership 29.8 per cent. were temporarily suspended or out of benefit.

payments made on account of temporary residence in the Blackpool district averaged during 1917 about 7s. 10d. per patient. But this statement is in conflict with another return, for the Southport district; here the payment averaged only 3s. 6d. per patient per annum. It may safely be assumed that in actual practice the standard rate adopted by the Insurance Committee of Manchester on an attendance basis of 2s. per office attendance and 2s. 6d. per home visit is *not* reached in the large majority of the panel practices.

Treatment of Panel Patients

It requires no extended examination into the actual experience under national health insurance to make clear the lamentable conclusion that the major part of panel treatment is devoted to minor ailments, or, as has been said, "to a minute of advice and a bottle of medicine." In large panel practices it is doubtful if the average consultation reaches five minutes to a patient, but this conclusion must not be applied to small panel practices, particularly in rural districts, where panel patients generally receive equal consideration with private patients. The argument has been advanced by Mr. W. M. Marshall, clerk of the Lanark Insurance Committee, that there is no foundation for the view "that the treatment of the panel doctor is confined to trivial complaints, and that for all serious illness the insured persons are left without care and attention except in populous centers where they may receive treatment at the voluntary hospitals." It has not to my knowledge been argued by any one familiar with the facts, that insured persons suffering from serious illness are left without care and attention. This is a question separate and distinct from the first, that the major portion of the doctors' time is consumed in trivial ailments. Mr. Marshall in his brief on medical service in Scotland properly draws attention to the fact that in Glasgow, for illustration, of the services rendered, only twenty per cent. were home visits, while eighty per cent. consisted of consultations at the surgeries of the panel doctors. He points out that "services rendered by the doctor are divided between consultations at his house or surgery, and visits at the homes of the patients. Naturally it is easier for a doctor to interview a dozen patients at his surgery during his consultation hour than to visit one-third of that number at their homes; but it is reasonable to assume that the majority of the consultations at the surgery deal with minor ailments." This being his own explanation of the large proportion of office consultations, he himself refutes his previous statement that the facilities provided for in the act are not confined to trivial complaints. As said before, in Manchester, out of a little more than a million services rendered, 86 per cent. were office attendances, while only 818 were night visits, and 138 minor surgical operations!

Treatment for Trivial Complaints

There has been no thorough inquiry into the actual practice of medical benefit. The facts concerning panel practice are largely a matter of personal knowledge, but from such investigations as I have made in England and Scotland, though necessarily limited in time, I have became absolutely convinced that in the larger panel practices the attention given to individual cases is not such as is called for in serious ailments as a prerequisite to satisfactory results. Mr. Marshall enumerates a list of diseases treated by panel practitioners in the course of their general practice, but this is by no means evidence that they were rightly treated, or seriously so. I personally have been present when a diagnosis was made of debility in an obvious case of incipient tuberculosis and when a diagnosis was made of dropsy in a case of malignant disease. The answer is that nothing can generally be done for these people except to give them comfort and relief, and there persists therefore the same fatuous reliance upon "a bottle of medicine" fostered by the practice of prescribing stock medicines, which practically standardizes mediocrity in pharmacy.

No one who has an extended personal knowledge of panel practice under national health insurance can be unaware of the enormous waste of the doctors' time in trivial complaints, the unnecessary prolongation of alleged illness for the purpose of wrongful gains, and the demoralizing effect of the system on the practitioner, who frequently is asked to certify to incapacity for work although full well aware of the facts to the contrary. Reference need only be made to the results of the medical referee system in the district of Ayr, Scotland, which have proved conclusively that a large proportion of persons drawing sick pay are full well able to work, but prefer to impose upon the funds. As long as wages are high and conditions of employment are satisfactory, this tendency will necessarily be reduced to a minimum, but even at the present time the evidence of widespread abuses is absolutely conclusive.

Urgency of a Full Investigation

The foregoing observations emphasize some of the practical difficulties experienced in the administration of national health insurance in Great Britain. A thorough inquiry into the entire matter has not been made and is not likely to be made for some years to come. There is a natural reluctance to reopen the whole question at a time when administration measures have not had a fair opportunity to be subjected to the test of actual experience. Only a Royal Commission could make adequate inquiry into every phase of a subject which has been controversial from the outset and is likely to remain so for many years to come. Only a report corresponding to the inquiries made by the Royal Commission on Friendly Societies which sat in the '70s and the Royal Commission on the Poor Laws which sat in the late '90s can meet the increasing demand for

full and impartial information upon questions of the utmost importance to the public.

Investigation by the Faculty of Insurance

Reference requires to be made, however, to a report of a Commission of Investigation into National Health Insurance, appointed by the Faculty of Insurance, and made public during the year 1917. This commission examined a large number of witnesses and considered written reports and communications from approved societies, etc., including in its deliberations the whole range of health services under the act, or (1) medical benefit, including attendance and drugs; (2) tuberculosis scheme (institutional or domiciliary); (3) sickness benefit; (4) disablement benefit; and (5) maternity benefit. The chairman of the commission was Mr. G. W. Currie and the vice chairman Mr. F. Handel Booth, formerly a member of Parliament and active during the passage of the act in 1911. It is said in this report that "the evidence tendered to us leaves us in no doubt that, regarded broadly, the medical services rendered represent a very considerable step in advance upon the conditions which obtained prior to the Act." But, it is said in continuation, "exactly how far this advance might have taken place in any case through the growth of public opinion is one of those matters on which unanimity of view need not to be looked for.* Very divergent testimony has been given as to the merits and demerits of the old system of club practice, poor law service, works clubs and private medical attendance as it existed five, ten and twenty years ago, but, after fully weighing the evidence, and, in particular, giving especial consideration to the opinions of witnesses whose testimony was in the main adverse, we have come to the conclusion just stated." It is so much the more regrettable, therefore, that the evidence was not printed and made public. The committee took occasion to say, however, that "We are indeed impressed seriously by statements made to us as to existing defects in the various services; but certain of them pertain mainly to administration; certain of them appear to be inseparable from any form of medical service involving an enormous working class population, many of whom spend their lives in an environment which, from a medical view-point, cannot

*It is said in the majority report of the Royal Commission on the Poor Laws (p. 377), that "when we consider the enormous improvements which have been made in the last thirty years in the quality of the medical assistance available to the sick poor we feel that a great debt of acknowledgment is due not only to the local government board by whose orders and initiative, as we have seen, the improvements have been chiefly carried out, but also to the local authorities, who, to the extent of their understanding, have in most cases endeavored to respond to the stimulus of the central authority." Yet this progress was totally ignored or set aside while a new authority was created, ostensibly for the purpose of dealing more effectively with the medical needs of the poorest poor. As a matter of fact this latter element remains subject, as heretofore, to the Poor Law Guardians, who, on practically every occasion, are found fault with as derelict in their duty, though, as here recognized, entitled to unstinted praise for the progress that has been made. Nor is it true that insured persons have been placed above the need of poor relief. According to a report for a representative London poor law union, out of 535 patients receiving indoor relief, 108 were insured persons. In this connection there may be quoted the conclusion of the majority of the Royal Commission on the Poor Laws, that "We are not inclined, therefore, to make medical assistance so attractive that it may become a species of honorable and gratuitous indulgence instead of a somewhat unpleasant necessity, resorted to because restoration to health is otherwise impossible." Yet this is precisely the result of national health insurance, which gives every encouragement to needless medical attendance while prolonged or chronic cases remain as heretofore largely subject to private treatment or the poor law.

possibly be described as favorable; and certain of them appear to us to be curable. In this latter connection we believe much might be secured by the organization of a system under which a second medical opinion could be easily obtained where it was required. The establishment of such a system was in contemplation when the war broke out, and we are in favor of its being brought into operation as soon as possible. It is obvious that given a limited number of doctors and an unlimited number of patients ideally full treatment and attendance is unobtainable, and that the closest approximation to it which existing resources and conditions render practicable is the true objective." This, however, is by no means a conclusive reply to the charge stated. The government assumed unconditionally a responsibility for the medical care of some twelve million wage-earners, and while earlier conditions may have been far from ideal, they were not a matter of obligation on the part of any one, but determined by circumstances largely outside of the control of those concerned. In this connection the following statement is particularly suggestive: "It is noteworthy that the most serious evidence tendered against the value of the Medical Services generally came from sources well known to have been actively associated with the promotion and launching of the Act and to have been intimately associated with its operation."

Suggested Inquiry into Medical Practice

The demand for a thorough inquiry into the medical side of health insurance is further emphasized by an extended letter to the London *Times* of January 28, 1920. This letter, by Mr. David Davis, member of the London County Council, and of the National Health Insurance Committee for London, etc., argues that "the time has arrived when a statutory committee or tribunal should be set up, in the interests of the general public, to hear complaints of negligence, etc., by them against members of the medical profession," for, "at the present time the patients of panel doctors under the National Health Insurance Acts are, in this respect, in a favored position, as every National Health Insurance Committee throughout the country is bound to set up a sub-committee whose primary duty is to inquire into complaints made against panel doctors by insured persons." Following a number of illustrations, reference is made to a doctor being deprived of a portion of his remuneration; and in a particularly bad case, of his removal from the panel. It is then said that:

"During the last three years I have presided at the hearing of over 200 complaints, and in most cases where a penalty has been recommended by my sub-committee the same has been unanimous. The recommendations, with notes of the evidence of each case, are reported under numbers to the National Health Insurance Committee (which sits in public), the doctors' names being withheld, and these recommendations, if confirmed, are then forwarded to the Minister of Health (formerly the National Health

Insurance Commissioners). A doctor has the right of appeal to the Minister and, if the recommendation is that the doctor is not a fit person to remain on the panel, the case is always reheard *(ad initio)* by a special committee appointed by the Minister."

But this procedure is quite unsatisfactory to some of the members of the medical profession, who believe that they should not have been deprived of the right of an appeal to the higher courts. Certainly the power placed in the hands of the Ministry of Health, being strictly judicial, is precisely such as would most easily admit of being seriously abused. Believing, however, that the interests of the insured persons are adequately safeguarded, Mr. Davis continues: "The general public are not, owing to the lack of statutory committees or tribunals [provided] with suitable powers, at the service of those who are not insured persons," for, he points out, that "the uninsured have practically little or no remedy against those members of the medical profession who may have treated them incompetently, negligently, or dishonestly. The doctors have protection societies, but the public have not. It is common knowledge that if a patient even with a bona-fide grievance desires to resort to litigation (which is both expensive and dilatory) he frequently finds that in consequence of the tenets of 'professional etiquette,' no doctor of any standing will give the requisite evidence against his brother practitioner unless absolutely compelled."

The foregoing emphasizes some entirely new aspects of the health and medical situation of Great Britain. There is unquestionably a growing demand for an impartial inquiry into all the facts of medical practice, whether affecting the insured or the uninsured populations. A parliamentary committee some years ago took evidence upon the subject of patent medicines and brought to light a large amount of abuse in the name of medical practice, urgently demanding far-reaching reforms. There can be no question of doubt that, to a considerable extent, medical treatment is given improperly for pecuniary gain, fostered by lax laws of advertising, as made evident by reference to any English newspaper accepting such announcements as a matter of commercial enterprise. Such an investigation would bring to light other abuses in the name of medical practice and unquestionably make available a mass of most urgently needed information as a basis for more rational legislation concerning the proper place of medical practice in modern plans and methods of social reconstruction and reform. A suggestion may here be made that if such an inquiry should ever be undertaken it would be advisable to consider the practical possibility of requiring attending physicians to enter the name of the disease on the prescription blank and thus make available a truly enormously valuable amount of information as to the diseases treated and the remedies prescribed, as an ultimate test of medical proficiency. It is only fair in this connection to add the concluding paragraph of the

letter from Mr. Davis, which reads: "Although it is the fashion in certain quarters to sneer at the National Health Insurance Acts in general and at 'panel practitioners' in particular, there are, in my experience, many conscientious gentlemen among the latter who are at least equal in qualifications and education to some of the highly-paid doctors not on the panel." But no one, to my knowledge, has advanced invidious reflections upon panel practitioners *per se*. The objections lie not against the panel doctor but against the panel system. It would be absurd to indict the major portion of the British medical profession as incompetent, when no body of practitioners has, on the whole, a more honorable and a more satisfactory record to show for years of faithful services, frequently resulting in but a very poor pecuniary reward.

The Problem of Adequate Remuneration Under Panel Practice

I cannot do better, perhaps, than to enumerate the more important recent deliberations which have taken place with reference to the readjustment of medical practice to changed conditions, partly resulting from the war, calling attention to the official documentary evidence as reprinted in the Journal of the British Medical Association from the beginning of 1919 to the present time.

(1) Annual report of Council, 1918-1919, British Medical Association, reprinted in the supplement to the *British Medical Journal*, dated May 3, 1919 (pp. 67-87, and pp. 80-83), considering chiefly such questions as the constitution of the Insurance Acts Committee, the annual conference report of local medical and panel committees, the question of moneys withheld from insurance committees, the required allowances for the increased cost of living and increased practice expenses, the proposed raising of the income limit for insured persons, the new agreement as to remuneration and the possible extension of the service for 1920, the practice of women practitioners under national health insurance, and, finally, the proposed National Insurance Defence Trust.

(2) Report of conference of representatives of various medical bodies. In the issue of May 17, 1919, there is an extended discussion of trade unionism and the medical profession, involving questions which lie outside of the present discussion, but which bear directly upon the future relations of the medical profession to the state (p. 100, supplement of *British Medical Journal*).

(3) An important letter on the question of remuneration under the insurance acts, addressed to the secretary of the Joint Committee of Insurance Commissioners by the Medical Secretary of the British Medical Association, Dr. Alfred Cox, is reprinted in the *British Medical Journal* of May 27, 1919 (pp. 102-3).

(4) A reply to this letter by the secretary of the National Insurance Acts Committee, Mr. E. Hackforth, dated June 23, 1919, was reprinted in the Insurance supplement to the *British Medical Journal* of June 28, 1919 (p. 140). This issue also contains reports of conferences and meetings at London, Norwich, Plymouth, Edinburgh and Leith, Sunderland, etc.

Resolutions of the Edinburgh-Leith Panel Committee

(5) As an illustration of the view-point of the organized medical profession, I quote the following resolutions adopted unanimously at a meeting of panel and non-panel medical practitioners held in Edinburgh and Leith, as reported in the *British Medical Journal* of June 28, 1919 (p. 142):

"1. That this meeting protests against the action of the Council in approaching the Commissioners with any policy that affects the interests of the profession before having ascertained the views of the members on the question.

"2. That this meeting protests against the action of the Commissioners in not inviting representatives of the Scottish Colleges to take part in the conferences.

"3. That this meeting regards the whole tenor of the report of the Insurance Acts Committee and the memorandum of the Commissioners as biased on the side of national insurance and as failing to take account of the strong desire of at least a large section of the profession to restrict as far as possible the range of contract practice.

"4. That the proposal to raise the income limit for insured persons from £160 to £250 be uncompromisingly opposed.

"5. That this meeting uncompromisingly opposes the raising of the insurance income limit above £160 per annum, inasmuch as that sum, fixed at the inception of the Act, was much too high.

"6. That this meeting is opposed to any extension of the Medical Benefit Section of the National Insurance Acts, except consultant's advice for the [at] present insured.

"7. That the proposed provision of expert services should be limited to the present class of insured persons.

"8. That free choice of consultant be given to practitioners and patients under the proposed expert medical service in each area.

"9. That when a doctor and patient are agreed that a second opinion is desirable, it should be obtainable by the doctor at once and directly without reference to the referee.

"10. That when a patient desires a second opinion and the doctor does not think it necessary, the question should be referred to the referee.

"11. That in submitting the patient for a second opinion the doctor should furnish a statement of the case as is done in private practice.

"12. That cases in which practitioners, patients or societies were alleged to have made excessive demands upon expert services should be investigated by a medical committee chosen by the profession and not by a lay or mixed committee.

"13. That an expert second opinion should be obtainable from practitioners who are known to the profession and public as possessing special qualifications for such, and from general practitioners of large experience who may possess the confidence of the profession to give expert advice.

"14. That the establishment of common surgeries [consulting clinics] would for obvious reasons be unnecessary.

"15. That medical referees should be appointed by the Commissioners.

"16. That medical referees should be practitioners having wide experience of general practice.

"17. That the duties of a medical referee should be restricted to checking claims for incapacity for work and to deciding whether an expert opinion is desirable.

"18. That investigation and action by non-medical bodies should be abolished.

"19. That this meeting disapproves of obstetric practice being included under the range of service under National Health Insurance.

"20. That insured persons should have the right to relinquish their medical benefit in exchange for some other form of benefit as nearly as possible financially equivalent to it."

It would be quite out of the question to enumerate and discuss the practically countless meetings of local medical and panel committees reported from week to week in the supplement to the *British Medical Journal*. They indicate, however, a truly enormous amount of professional time necessary for deliberations upon matters which do not bear directly upon the question of efficiency and administration in the interests of the patient and the public at large. They are largely limited to questions of pecuniary interest to the physician, and while important on general grounds, are often clearly opposed to the advancement of medicine as a healing art. The question of adequate remuneration for medical services is not debatable. If any class of men are entitled to

proper compensation for their services it is the doctors and pharmacists, who are indispensable to the welfare of the community. But it cannot be to the interest of the public that a bureaucratic system should come into existence under which questions of remuneration, terms and conditions affecting them are constantly recurring to the disadvantage of the practice of medicine in its restricted and proper sense.

Conference of Panel and Medical Committees

(6) These observations are emphasized by the report of the special conference of representatives of local medical and panel committees held in London, July 17-18, 1919. The report of this conference takes up nearly fourteen closely printed pages of the supplement to the *British Medical Journal*, July 26, 1919, the discussion being participated in by 153 representatives of 154 insurance areas of England, Scotland and Wales. More than 140 motions and amendments were considered, illustrating the widely divergent views held on important matters of detail. Among the questions considered with reference to the conditions of service were such as the distribution of the local pool, the limited liability of practitioners, the problem of temporary residents, the limitation of panel lists, the minimum assured payments to entrants into practice, the problem of anaesthetics, the so-called "floating sixpence,"* the freedom of change of doctors, the drug fund, the range of services, the involved problem of differences in professional skill, attendance in pregnancy and labor, compensation for preventive treatment, surgery accommodation, emergency treatment, parliamentary grants in respect of increased practice expenses, the mileage fund and the rural practitioner, the keeping of records, the making out of certificates, the agreement for medical services, the suggested additional services, the proposed system of medical referees, the possibilities of group medicine or general practitioners' clinics, and, finally, the organization of the medical profession and the National Insurance Defence Trust! The last two questions are of late assuming profound importance in Great Britain. (Of much value in this connection is an address by Dr. Alfred Cox, the Medical Secretary of the British Medical Association, on "Why Should the Medical Profession Be Organized and How Should It Be Done?" printed in the supplement to the *British Medical Journal* of March 22, 1919.)

Conflicting Views of the Medical Profession

The British Medical Association can hardly be said to represent the considered view-point of the British medical profession in its present position, largely brought about by the radical change in practice conditions in consequence of national health insurance. Under date of July 8, for illustration, the southern branch of the British Medical Association adopted the following resolution:

*The so-called "floating sixpence" or marginal allowance for doctors' compensation, depending upon economy in drug expenditures has been done away with under the amended law of 1920.

"That this meeting of the Southern Branch is of opinion that the British Medical Association, as at present constituted, has been proved incapable of adequately assisting the profession with regard to the Insurance Acts. It therefore suggests that the Association should so alter its constitution as to be able to effectively deal with this and any similar legislation in connection with national health, and if this be impossible, that these matters should be left to a body *possessing trade union power.*"

In communicating this resolution, Dr. Horace Brown, of Bere Alston, took occasion to say:

"I submit that the above resolution and instruction prove that there is grave dissatisfaction among the members of the British Medical Association at the manner in which the interests of the profession are at present being safeguarded, and I again appeal to those who control the affairs of the Association to allow the whole matter to be fairly and squarely thrashed out aboveboard."

In the same issue of the *British Medical Journal* is a letter from Dr. Alfred M. Billings, of Monton Green, containing the suggestive statement that "it must be quite obvious from the letters published in the *Journal* and reports from the group conferences that the proposals contained in M. 25 cause profound dissatisfaction and distrust."

(7) In this connection the editor of the *British Medical Journal,* under date of August 2, 1919, took occasion to point out that "it is to be noted that in the Representative Meeting and in the Conference, as well as throughout the profession, there has been disclosed an almost unanimous discontent with the present insurance medical service as it affects both panel practitioners and insured persons."

And referring to the fact that the broad lines of the service remain as before, the editorial observes: "The innumerable irritating details that have been superimposed by regulations are seen to have distorted what might conceivably have been a sound medical service into a service which, to the better class of practitioners, has become hatefully irritating, and in the hands of less conscientious practitioners is as slipshod as can possibly be imagined." It is thus frankly conceded that the service is neither to the satisfaction of the panel practitioner nor of the panel patient. Reference is made to resolutions that were carried in favor of the immediate establishment of clinical and pathological laboratories for the whole population, but the suggestion was disregarded.*

(8) The increasing restlessness of the medical profession and growing discontent with the results of the negotiations with the British government

*Of special importance is the report of the proceedings of the Arbitration Committee reprinted in *British Medical Journal,* March 13, 1920 (p. 67).

are further illustrated by an address on "The Organization of the Profession," by E. Kaye Le Fleming (supplement to the *British Medical Journal,* October 25, 1919, p. 91), containing the suggestive remark that "the necessity for a general strike is likely to arise in the very near future." The conclusions are summarized in the statement that:

"1. An insurance crisis is imminent.

"2. That all sections of the profession will be involved directly or indirectly in this and in the National Health legislation which is impending.

"3. There is urgent need of joining some organization."

Discussion of Remuneration for 1920

(9) Under date of November 8, the *British Medical Journal* published a memorandum by the Insurance Acts Committee (M. 22) on the proposed terms of remuneration for 1920. The clear recognition of the trade union principles* which may be said to underlie the negotiations and the threat of a discontinuance of service are set forth in the following four fundamental principles or basis considerations for a readjustment of the fee question:

"1. The altered value of money.

"2. Increased work and responsibility owing to the impaired health or disabilities of discharged or demobilized men, and of similar war effects among other insured persons.

"3. Certain modifications of service under the proposed new arrangements.

"4. Newly or increasingly recognized responsibilities of general practitioners in connection with public health and medical research."

On the basis of the foregoing memorandum with reference to the question of the cost of living and the increase of practice expenses, it was recommended that, as a result of the calculations, the basic fee of 7s. 3d. should be increased by sixty per cent. on account of the increased cost of living, or 4s. 4d. Additional thereto there was to be an increase of ten per cent. in respect of the increased amount of work and responsibility in regard to the impaired health of returning soldiers, etc., and a further ten per cent. in respect of new liabilities and new responsibilities under the new regulations, making a total of 13s. 9d., which was subsequently reduced to 13s. 6d. in the negotiations with the Ministry.

*See Dr. Brackenbury's reports and the reports of the proceedings of the Arbitration Committee, *British Medical Journal,* March 23, 1920 (pp. 67-72).

The Official Point of View

(10) The reply to the memorandum by the Ministry of Health is given in the same issue of the *British Medical Journal* (p. 100-103). The conclusions were not accepted by the Ministry of Health as final, but an offer was made of a compensation of 11s. per capita, which was refused by the committee in charge of the negotiations. The calculations presented by both sides to the controversy are typical of trade union disputes, resting on the one hand upon the cost of living and on the other upon the exact amount of service rendered as measured in hours and minutes of working time. In this respect it may safely be asserted the British Medical Association has drifted far from accepted professional standards, and what was formerly a profession is now reduced to the status of a trade.

(11) (An important discussion in this connection is a letter on "The Forgotten Factors," by Gordon Ward, M.D., of Sevenoaks, printed in the *British Medical Journal* of November 8, 1919, p. 110).

(12) The new terms of insurance service were discussed at a meeting of the North London practitioners' committee, and printed in the November 15 issue of the *British Medical Journal*, together with reports of the Buckinghamshire practitioners' committee, the Warwickshire and Coventry local medical and panel committees, etc. The last named committee adopted a resolution to the effect that "the acceptance of an inclusive capitation fee of less than 16s. would not be reasonable."

(13) A rejoinder to the reply of the Minister of Health on the question of the remuneration of insurance practitioners (M. 26) was published in the supplement to the *British Medical Journal* under date of November 22, 1919. This is an important document briefly restating the main arguments advanced in the original report, concluding with the suggestive observation, that "The State can have what it pays for. If the insurance service is to be what the committee, the profession and the Ministry of Health wish it to become, the remuneration can scarcely be calculated on a basis less than that which the committee has suggested."

Growing Opposition to Governmental Control

The increasing dissatisfaction of the profession with the proposed terms of remuneration on the part of the Ministry, or, as previously stated, 11s. per capita, is made evident by the resolutions adopted by the London panel committee, reading in part:

"That the Panel Committee for the County of London cannot recommend the practitioners on the panel in London to accept service under the Medical Benefit Regulations, 1920, until a satisfactory rate of remuneration has been agreed to." (*British Medical Journal* supplement, November 22, 1919, p. 124.)

In the same issue there is an important letter by Dr. G. M. Hodges, of Deddington, having reference to the rural practitioner and the increased practice expenses, illustrating the precarious status of country practice and the lack of adequate consideration of important questions obscured by the more pressing demands of practitioners in congested industrial districts.

From the same point of view it is significant that in an editorial in the *British Medical Journal*, of November 22, 1919, the statement should be advanced that "the general tenor of the Ministry's reply can only be described as officially unsympathetic towards panel practitioners," and, "if this attitude is persisted in the prospects cannot be regarded as bright for the insurance service," for "it is not too much to say that in these negotiations the health of the people and *the future of the medical profession are at stake;* and this is no time for the exhibition of adroitness in debate by practised government hands."

Proposed National Insurance Defence Trust

(14) The whole question was once more reviewed at the annual conference of representatives of local medical and panel committees, held in London, November 27-28, 1919, and reported upon in the supplement to the *British Medical Journal*, December 6, 1919. Dr. Brackenbury, chairman of the Insurance Acts Committee, moved: "That the Regulations cannot be accepted unless at the same time the remuneration is upon a satisfactory basis."

The resolution was unanimously adopted and followed by an extended discussion of the question of mileage, the amount of the capitation fee, the question of arbitration, the duration of the new agreement, and the 1920 draft regulations, to which more extended reference will be made later. The discussion also included the important question of the transfer of a panel practice on the death of a practitioner, the question of dispensing by practitioners, emergency treatment, the functions and duties of the distributing committee, the payment for drugs and appliances, and the right of appeal, in connection with which Dr. Sidney Matthews moved the following amendment:

"That any person aggrieved by the removal of his name from the list may, within three months after the date on which notice is given to him by the Minister that his name has been so removed, appeal to the High Court, and on any such appeal the High Court may give such directions in the matter as it thinks proper, including directions as to the costs of the appeal, and the order of the High Court shall be final and conclusive, and not subject to an appeal to any other court." (See pp. 32-34.)

Among other questions considered were complaints against practitioners, the duty of practitioners to refuse to accept an applicant for panel practice, temporary arrangements, surgical accommodations, the proposed

prohibition of repeated prescriptions, the appointment of referees and, finally, as on a previous occasion, an extended discussion of the proposed National Insurance Defence Trust. The enumeration of these subjects is for the purpose of clearly emphasizing the complex nature of the relations now existing between the medical profession and the government, most of which are subject to countless rules and regulations, only partly consolidated into the medical benefit regulations of 1920.

Basic Principles of Panel Remuneration

(15) A conference was held December 4, 1919, at the Ministry of Health between the Minister of Health and the representatives of the Insurance Acts Committee of the British Medical Association, including Sir T. Clifford Allbutt, president of the British Medical Association, who called attention to the historical fact that "in club practice the capitation fee had been 4s. and that on the whole the service had not been unsatisfactory. With the passing of the insurance act the capitation fee had to be regarded in the majority of cases as a sum which would provide reasonable remuneration for a doctor whose insurance patients occupied the greater part of his time,"* and that "they now had to consider: *(a)* The fall in the value of money, and *(b)* the increased demands on the doctor and the improved standard of work." In this connection he referred to his experience in consulting practice, according to which "a patient required one hour of the doctor's time for work for which twenty years ago a quarter of an hour would have been regarded as ample." As a matter of fact panel patients (at least in industrial districts) are fortunate if they receive on an average as much as five minutes in consultation at the surgery.†

Dr. Brackenbury in defence of the proposed increase of the capitation fee to 13s. 6d. also laid emphasis "on the amount of time necessary to deal satisfactorily with patients as compared with twenty years ago, and said that the general experience was that insured persons were increasingly appreciating their opportunities, and were increasingly asking the

*It has frequently been asserted that panel practice takes up about three-eighths of the doctor's available working time. Even if this statement should be strictly correct as a statistical average it would be utterly without meaning in considering the abuses of the panel system. Dr. William A. Brend, in his treatise on "Health and the State," points out that, "a considerable number of panel doctors, working without partners or assistants, have 2,000 insured persons on their lists; some have 3,000, and even 4,000 is reached. Most of these are undertaking private practice as well, and if we assume that on the average each insured person connotes one and a half dependents, it follows that a doctor with a panel list of 2,000 has actually a total clientele of some 5,000 persons. Many instances have been given of the way in which doctors with these large practices rush through their work in order that they may see all their enormous number of patients. Dr. Alfred Salter, speaking in 1914 at a public meeting in support of a national medical service, stated that he saw 'on an average 76 cases in the morning and 92 in the evening. It worked out at 3½ minutes for each patient, 1½ of which was taken up in writing. Patients had to wait on an average 2½ hours for their turn, unless present at the very start.' " That this was not an isolated case is made evident by a mass of additional information. It does not, however, seem necessary to quote more than the following statement by Dr. Brend: "In an investigation at Cambridge by the Insurance Commissioners into the conduct of a panel practitioner, whose dispenser had written prescriptions and given medical certificates, it was shown that the practitioner's consultations and visits to panel patients in 1914 amounted to 12,457, and that with private patients the total was brought up to 20,660." (See Brend's "Health and the State," pages 178-9; also the *Medical World*, April, 1914, and the *Hospital*, September 18, 1915.)

†An invaluable source of information is Brend's "Health and the State," E. P. Dutton & Co., New York, 1917.

insurance doctors to visit them at their homes." The Manchester figures previously quoted and according to which out of more than a million services only about fifteen per cent. were domiciliary visits prove conclusively that the major portion of the doctors' work consists in attending to ailments of comparatively slight importance. Of value in this connection is a statement by Dr. D'Ewart, of Manchester, and a member of the Manchester Insurance Committee, who explained that in Manchester "insured persons were treated on an attendance basis, and the doctor was paid for work done." He stated that in 1913 claims were made for 1,400 operations, and in 1918 for only 118! Figures for anaesthetics were 192 in 1913, and only 8 in 1918! It was evident from these figures that insurance doctors disposed of the majority of their difficult cases by sending them to hospitals. As regards visits, the number paid in 1913 was about 250,000, and in 1918 only just over 200,000. Surgery attendances in 1913 were 1,250,000, and in 1918, 866,000. These figures, he said, were based on approximately the same number of insured persons over the whole period (about 250,000).* His claim was that the insurance practitioners had consciously designed their work to represent a fair return for the remuneration they received. Even on this restricted service the insurance doctor in Manchester was being paid less than half what he was paid by guardians for treating patients under the poor law, and he himself had suggested to his insured patients that they were not paying enough in contributions, and he thought that this was fairly generally recognized. The better type of doctors was dropping off the lists. Since 1913 only one doctor who was not originally on the panel had come on the panel, and from ten to twelve had resigned. These astonishing allegations were not contradicted but they are fully sustained by the official statistics of the Manchester Insurance Committee. It, however, should be said that Dr. Addison, the Minister of Health, agreed that the Manchester figures should be carefully examined and that at any rate they seemed to show "that the insured persons in Manchester had been led to expect a better service from the same doctors [than] if treated as private patients." This, it may be said, is generally the case, and a strong tendency has developed towards the employment of private physicians at the patients' expense regardless of the insurance.

The Cost of an Adequate Medical Service

(16) The question clearly involved in the controversy is the true cost of adequate medical service.† It goes without saying that standards can-

*According to the year book of the Manchester Insurance Committee for 1919 the number of names on the index slips, or persons entitled to medical benefit, was 298,709, but in addition there were index slips for other persons apparently not entitled to medical benefit numbering 137,138. The number of doctors on the panel for 1919 was 254, of which 42 were still serving with H. M. forces. The number of chemists for the year was 156; the number of all prescription forms dispensed during the year 1917, including domiciliary and temporary resident scripts, was 765,776, showing a continuous reduction since 1914, when the number of such prescriptions was 1,213,572.

†The true cost of an adequate medical service has never been determined. No facts have been forthcoming as regards the actual earnings in the British medical profession. All the arguments advanced in support of a higher capitation fee rest upon more or less theoretical assumptions. In this respect even the Plender report of 1912 falls short of the required number of practice accounts and extent in the area of observation. (See note on page 55.)

not be raised without an increase in the expenses of all the contributing factors, aside from the urgency of an adequate remuneration of the doctor himself. Dr. Addison evaded a full discussion of the question involved by merely restating his point of view that "the Government could not give 13s. 6d., involving an increase of 4s. 9d. on the present payment of 8s. 9d., including war bonus, or an increase over the original 7s. 3d. of 6s. 3d.—that is, something like eighty per cent. or ninety per cent. The demand was for a further three-and-a-half million on top of the existing war bonus. He did not see how it could be possible for the Government to accept such a proposal."* This, in brief, is a frank admission that the British government is unable to fulfil its obligations to provide a satisfactory medical service to the insured population now hopelessly involved in a costly system of bureaucratic administration from which it will find it most difficult to extricate itself.

Changed Conditions of Medical Practice

(17) A conference was held on December 12, 1919, at Steinway Hall, London, of the Federation of Medical and Allied Societies, partly organized for more effective fighting purposes. The chairman, Sir Malcolm Morris, took occasion to say that "the present scheme of insurance was not the best that could be devised," but he expressed the view that "a committee or Royal Commission should be appointed to devise something better for the public, whose interests were those of the medical profession." The meeting is but one of many further evidences of a growing discontent with the new terms of remuneration and the new regulations, as voiced in a letter by Dr. Alexander Fraser, of Manchester, dated December 27, 1919, reading in part that "during the first year of the operation of the Act the Manchester doctors treated their insurance patients in the way they had hitherto treated their private patients. They were promised by the Panel Committee that as far as could be foreseen the remuneration would be 2s. per attendance and 2s. 6d. a visit.† At the end of the year, after a drastic cutting down of the attendances and visits to an average for all practitioners and payments restricted to that average or less, the doctors were paid round about 60 per cent. The floating sixpence was

*The financial status of national health insurance with special reference to the cost of medical service has been set forth in a statement of the Minister of Health communicated to the House of Commons on June 3. It is said that "the cost on the present actuarial basis of the scheme under the proposed new benefits would be increased by £17,950,000, of which £3,400,00 would fall on the Exchequer and the balance on the insured persons and their employers. But, if the benefits for women were on such increased basis, made equal to those for men, the total cost would be still further increased by £2.600,000, of which £709,000 would be payable by the State. The total (but only approximate) cost of parliamentary grants and contributions on account of National Health Insurance being placed at about £7,000,000 for the year 1920-1921." (*British Medical Journal*, June 12, 1920, p. 808.)

†It has been emphatically denied that in the government calculations a basic fee of 2s. per attendance was accepted in principle, it being said that the use of the figure was merely for the purpose of estimates and calculations. As observed in a statement by Dr. Brackenbury, the Insurance Acts Committee "had never said that the scale of fees of 2s. for a consultation, 2s. 6d. for a visit, etc., was a scale that was actually intended to be paid; but they were certainly not token amounts, they were amounts set out as being approximate to those which were in fact being received by doctors at the inception of the Act and which according to expectation at that time the capitation fee might not unreasonably be expected to work out." (*British Medical Journal*, March 13, 1920, p. 67.)

entirely swallowed up, and more than that, the chemists strove to recover this sum from the doctors. After a long controversy the matter was settled, several doctors being heavily surcharged. This object lesson was not lost upon the medical men of Manchester. It was clearly demonstrated that the Government had never intended to pay for a service equal to a private practitioner service. The coat had to be cut according to the cloth, and the Government are now getting what they are paying for—*a mere mockery of a service.*"

(18) In a letter contributed to the same issue of the *British Medical Journal,* Dr. Philip L. Benson, of Steeple Claydon, Bucks, makes the statement that the Manchester figures previously quoted have amply proved that "the present capitation fee was even at the inception of the Act totally inadequate."

Increasing Dissatisfaction and Antagonism

The controversy continued during the early part of 1920, the situation being briefly summarized at the time in an address on "The British Medical Association: Its Work and Critics," by Dr. Alfred Cox, as reported in the *British Medical Journal,* January 3, 1920, in part as follows:

"Mr. Lloyd George's first offer of remuneration for work under the Insurance Act was 6s. inclusive of cost of drugs. The final offer was 9s. and the difference was due entirely to the action of the Association which in the three years 1910 to 1913 spent £30,000 of its own money, in addition to money subscribed to a voluntary fund, in organizing the profession to refuse the offer of the Government and to improve the Insurance Act from our point of view. Now there are, roughly speaking, fourteen million insured persons and the extra 3s. has been paid for six years. It is therefore easy to show that from 1913 to 1919 the sum of £12,600,000 has been paid to the profession which they would not have had unless the Association had done the work referred to. As there are, roughly, 14,000 insurance practitioners, the average extra amount put into the pocket of each during the past six years is £900, not to mention the war bonuses and grants for practice expenses also secured by the work of the Association."

The increasing antagonism of members of the medical profession is emphasized in numerous letters to the *British Medical Journal,* including a suggestion by Dr. T. Strethill Wright, Okehampton, Devon, that the medical profession "must be united and organized. [For] Dr. Addison will not listen to our representatives. Very well. Break off negotiations and let all panel practitioners be invited to send in their resignations from the panel to the Local Medical Committees by a certain date, a

formal guarantee being given that these shall be returned if less than seventy-five per cent. respond to the call."*

Dr. M. C. S. Lawrance, of Earlestown, Lancaster, complained that he had not been paid at the per capitation rate of 7s. or 8s. 9d., as shown by a statement, according to which "the amount of the individual doctor's credit is £230,835, 8s., 9d., but the amount *available* to pay that sum is only £187,799, 1s., 7d., or 81.4 per cent." And quoting his own case, he points out, "Instead of receiving £252, 12s., 3d., I only receive £205, 10s., 4d., a matter of £47 less." He therefore argued that the existing situation simply amounted to "a bankrupt paying his creditors 15s. in the £ instead of 20s.," and he adds that the eighty-one per cent. payment "really means we are paid 5s. 6d. per head instead of 7s." *(British Medical Journal* January 31, 1920.)

The bitterness of the controversy has been increased by a material broadening of the range of the practitioners' duties. Under the new regulations the practitioner is required:

"To furnish in writing to the medical officer any information which the latter may require with regard to the case of any patient to whom the practitioner has issued or declined to issue a medical certificate of incapacity for work.

"To meet the medical officer when the latter so requires, for the special purpose of examining, in consultation, any patient in respect of whom the practitioner has sought the advice of the medical officer.

"To afford to the medical officer, or to such other person as he may appoint for the purpose, access at all reasonable times to any records kept by the practitioner under these terms of service and to furnish the medical officer with any such records, or with any necessary information with regard to any entry therein, as he may require; and

*Of historical value is a resolution adopted by the Cheshire local medical and panel committee, reprinted in the *Lancet*, under date of January 31, 1920, reading in part:

"(i.) That this Committee expresses its most emphatic disapproval of the remuneration offered by the Government; and regrets that the I.A.C. thought fit to exercise its authorisation to ask for arbitration when the Government's offer proved to be such a low figure as 11s. (ii.) This Committee notes with especial regret that the terms of service for which the remuneration is offered are 'the proposed Medical Benefit Regulations, 1920, as published in December last' which regulations (*a*) retain the provision by which the Minister may be at one and the same time accuser or complainant, and the judge or arbitrator (Regulation 57), the accused having no appeal—a provision which in the opinion of this Committee is contrary to the spirit of English law; and (*b*) introduce a new provision [16 (c)], detrimental to the transfer of practices, which greatly diminishes their capital value; and (*c*) impose a new obligation on practitioners [First Schedule, Part 1, 5 (*c*) and Model Allocation Scheme 5 (i) and (ii.)], requiring them to attend any insured person on the list of another doctor in an accident or sudden emergency if that doctor be not at the moment available, for a fee to be deducted from that doctor's remuneration."

In the answer made to the case presented by the Insurance Acts Committee in behalf of the government, it is said, from the point of view of the Treasury, the doctors were, in effect, asking that the pre-war capitation fee be doubled, and that this would represent a total cost of some £5,000,000 over the pre-war figures. Such enormous sums naturally make the negotiations a matter of serious political concern, and they make it a foregone conclusion that all future negotiations will tend more and more to become political rather than professional in character and intent.

"To answer any inquiries of the medical officer with regard to any prescription issued by the practitioner, or to any statement made in any report furnished by him under these terms of service."

Refusal of Government to Accept the Recommendations of the Insurance Acts Committee

(19) With a full knowledge of the foregoing and much additional information disclosing a truly lamentable amount of discontent on the part of the medical profession, the Ministry of Health, under date of January 14, 1920, announced that the government after fullest consideration was prepared to increase the yearly capitation fee to 11s., subject to certain conditions, to take effect from January 1, 1920. The government at the same time announced its willingness to make an annual mileage grant of £300,000 for distribution amongst practitioners engaged in practice in rural areas in England and Wales. The letter from the Ministry of Health is reprinted in the *British Medical Journal* of January 17, 1920 (p. 15).

(20) The report of the conference which was had with the Minister of Health and the Insurance Acts Committee on January 14, on the subject of medical remuneration, is reprinted in the supplement to the *British Medical Journal* of January 24, 1920. The interesting statement was made by Dr. Addison on this occasion that the increased remuneration of medical practitioners represented a sum of about £2,000,000, and that the total cost of medical benefit for Great Britain would be approximately £10,000,000. This cost it must be considered applies to from twelve to fourteen million insured persons, making allowance for the non-application of medical benefit to Ireland.* The announcement by the Minister concluded with the statement that the principle of arbitration had been accepted by the British Medical Association. At the same time an announcement was issued to the effect that for the foregoing and other reasons the weekly contributions were to be increased by 3d. in the case of both men and women, 2d. of which was to fall on the employer and 1d. on the employed person. The normal rate of sickness benefit was to be increased to 15s. in the case of men and 12s. in the case of women. Disablement benefit was to be at the rate of 7s. 6d. a week for both men and women, and maternity benefit was to be increased from 30s. to £2.†

*Regardless of the enormous amount of reports and data on the finance of national health insurance, it is practically impossible to ascertain with entire completeness a statement of the cost of the entire service for England, Wales, Scotland and Ireland. However, according to a recent statement made in Parliament by Mr. Bonar Law, the total cost of national health insurance from its inception to December 31, 1919, was (as respects England and Wales) in round figures, £162,000,000—namely, contributions of employers and employed, £119,000,000; Exchequer grants, £43,000,000. The amounts paid for administration and benefits were £21,000,000 and £84,000,000, respectively. For Ireland the total cost of national health insurance had been £7,700,000, of which £5,200,000 represented contributions of employers and employed persons and £2,500,000 Exchequer grants or Parliamentary gratuities. The amounts paid out for administration and benefis in Ireland were, respectively, £1,500,000 and £3,700,000. The data for Scotland at the time the statement was made were not available.

†The amended national health insurance bill of 1920 became a law on May 20, 1920. Practically every original proposal for changes in benefits and contributions was adopted without extended debate. The bill, in the words of a distinguished member of the House, "was rushed through without a proper opportunity for debate and consideration."

The Arbitration Award

(21) The appointment of the board of arbitrators was announced by the Ministry, in the supplement to the *British Medical Journal* of January 31, 1920. The board did not include a single representative of the medical profession, having for its chairman a Master of the Bench of the Inner Temple, and for its other two members the president of the Council of the Institute of Bankers, and a member of the Royal Commission on Income Tax. The terms of reference limited the board to the question as to "what should be the amount of the capitation fee on the basis of which the Central Practitioners' Fund should be calculated so as to afford fair remuneration for the time and services required to be given by general practitioners under the conditions set out in these regulations, in connection with the medical attendance and treatment of insured persons."

The report of the arbitrators as subsequently published* did not present all the evidence which it may be assumed was collected and which would be a matter of profound interest. There could be nothing more convincing than the numerous letters on the subject contributed to the *British Medical Journal* and the *Lancet*† on the controversial aspects of the question under consideration, as perhaps best illustrated by the following letter from Dr. Edward J. Cross, of St. Neots, January 7, who states, in part:

"On December 11th, 1919, I received from the Clerk to the Bedfordshire Insurance Committee a cheque for £5 16s. 8d. as a final payment for 1918. This makes the total amount paid to me for 1918 up to £43 5s. 7d. The Clerk tells me that the mean average number on my list was 139.25. Therefore I actually received about 6s. 2d as a capitation fee.

"Why (I do not dispense) do not I receive what I understood was the promised amount—namely 7s. 6d. for each person on my list? Why should 17.6 per cent. be deducted as the inflation of my mean average number and 8.32 per cent. be added for unallotted persons? How are these figures arrived at?"

To these and countless similar questions no satisfactory answer is or has been forthcoming. In preparing the case for the board of arbitration the Insurance Committee had employed the assistance of the distinguished economist and statistician, Professor A. L. Bowley, whose report in full detail, however, has not been made public.‡ Instead of being inclined to accept 11s., the capitation fee offered by the government, the profession assumed the view-point that even the 13s. 6d. proposed by the Insurance Acts Committee was inadequate. In an extended letter on insurance remuneration, contributed to the supplement to the *British Medical Journal*, Febru-

**British Medical Journal*, January 12, 1920, p. 808.

†See reference on page 57 to letter of Dr. M. C. S. Lawrance, *B. M. J.*, January 31, 1920.

‡See Professor Bowley's Memorandum, *British Medical Journal*, February 28, 1920, p. 53.

ary 7, 1920, Dr. Thomas Wright, of Greyholme, Aldershot, argued in favor of a per capitation fee of 15s. as more in proportion to the increased cost of living and the broader range of the practitioner's duties. Obviously a limitation of the number of names on the panel would make the position of the panel practitioner still more precarious. Dr. H. U. Gould, of Shaftesbury, in a letter to the *British Medical Journal*, February 14, 1920, points out the serious effects of such a restriction in the case of rural practitioners. He also directed attention to the expense involved in attendances at meetings of panel committees and the time lost, assuming in his own case a loss of nearly three-quarters of a day's work to a meeting.

It is difficult to understand the utter disregard of a timely protest on the part of those really familiar with the facts, otherwise than that the sole principle underlying the passage of the National Health Insurance Act was political and not social. In a letter to the *British Medical Journal* of May 20, 1911, Dr. P. R. Cooper, of Bowdon, for illustration, took occasion to point out that "The medical profession has found by bitter experience the principle of a capitation fee to be in the interest of neither patients nor medical men. The principle of payment according to work done is the only just and fair method that can be devised, short of a system of properly salaried medical officers. It is surely obvious now that neither the amount nor the method of remuneration will ever be satisfactory on any capitation basis that will ever be allowed by the government. What infinitesimal fraction of 1d. per visit will it make whether the capitation fee be fixed at 4s. or 5s. per annum? In neither case is it adequate, nor in my opinion, would it be if the amount were doubled or even trebled. . . . I have all along held the principle of per capitation fee to be a bad one and . . . I am satisfied it will not answer universally, as a national scheme should." The long intervening period of years has fully justified these suggestions, which, if acted upon at the time, would have prevented the inauguration of a system "neither to the interest of the patient nor of the medical profession."

The refusal of the Ministry to accept the proposed terms of remuneration naturally accentuated the demand for a more effective fighting organization. The subject was fully discussed at a conference of various medical bodies, including the Association of Panel Committees, the Medico-Political Union, and the Medical Parliamentary Committee, the Medical Women's Federation, the National Medical Union, etc. At this meeting it was suggested that there should be a recognition of the profession as a trade union as a possible valuable adjunct in medical organization, and, furthermore, that "the British Medical Association and the Medico-Political Union recognize that there is an important divergence of view between them on the subject of professional trade unionism;" but the difficulty though taken note of was not overcome.

The Position of the British Medical Association

(22) Under date of February 28, 1920, the *British Medical Journal* published in full a memorandum by the president of the British Medical Association, Sir T. Clifford Allbutt, K.C.B., including the case presented on behalf of the medical profession by the Insurance Acts Committee of the British Medical Association. This document is one of the most important contributions to the literature of national health insurance, being a reasoned statement of the view-point of the organized British medical profession, prepared with the aid of Professor Bowley and others familiar with the technicalities of controversies of this kind. The memorandum includes calculations by different methods of arriving at a fair remuneration, typical of trade union disputes. Most illuminating are the observations on changes in the expenses of medical practice, the increased cost of living, and the increased demands by certain classes upon the attention of the medical practitioners, including demobilized men, not invalided, as well as the effect of war conditions on the health of other sections of the community. The cost of the increased responsibilities under the new regulations is set forth in considerable detail, with observations on the increased stringency of conditions of service and the range and standard of service under the new conditions. The latter are summarized as follows:

(a) Advice and treatment to insured persons when actually ill, with a view to relief and cure, if possible.

(b) Advice as to how treatment outside the scope of the practitioner's agreement can best be secured and such help as will enable the patient to take full advantage of such treatment.

(c) Advice in matters of personal and domestic hygiene, where needed and as opportunity arises, with a view to the preservation and improvement of the health of the individual and family.

(d) Cooperation with medical officers of health and others in matters of sanitation and public hygiene with a view to the prevention of disease in the community.

(e) Such investigation in the incidence, beginnings and source of disease as may assist medical research both in preventive and in clinical matters.

The intricacies of the calculations are such as to preclude a clear grasp in matters of detail on the part of the entire profession, but it is evident that once this method was adopted it had to be carried forward to its logical conclusion. Such items as the income factor, and the comparison of the income with that earned in comparable circumstances, the proportion of total work properly assignable to national insurance,* the

*The neglect to present actual data of earnings and expenses with a precise differentiation of the income derived from panel and private practice is most regrettable. It may safely be asserted that a satisfactory solution of the difficulty is impossible as long as the remuneration depends upon theoretical calculations and not upon actually ascertained experience.

calculation of income to be derived from various capitation rates, the capitation fee computed from an average fee per item of service, all illustrate the complex nature of the calculations and the practical hopelessness of arriving at a result satisfactory to men of a widely different degree of intellectual or professional capacity. The memorandum by Professor Bowley is largely limited to the increasing cost of food, and the average family expenditure of a family including 2.1 children and 2.6 servants, all typical of trade union disputes, as best emphasized, perhaps, in the recent negotiations with reference to the minimum compensation of dock labor. But on the whole, the argument is an able presentation of the economic circumstances of the profession and the need of more adequate remuneration, although it would have been better if actual facts of income and expenditure had been presented, rather than a plethora of theoretical assumptions.*

The Position of the Government

(23) The reply in behalf of the government in the case as presented to the arbitrators on behalf of the insurance practitioners was published in the supplement to the *British Medical Journal* of March 6, 1920. This is an even more interesting and important contribution to the literature on the subject of medical remuneration, presenting the reasoned views of the Ministry of Health, which are certain to prevail as long as the present government continues in power.† An interesting observation in this statement is the discussion of the inherent difficulty attending a flat rate of remuneration. This statement, in its entirety, is as follows:

"With respect to the considerations stated in sub-paragraphs (ii), (iii) and (iv) of paragraph 3 of the Case, due regard must be had to the inherent difficulties attendant on a flat rate of remuneration that must be paid uniformly to practitioners of varying degrees of professional efficiency. The number of doctors necessary to attend the fourteen million insured persons is so large that, even were selection practicable, it would be impossible to confine the choice to the best. Moreover, *the Insurance Acts do not admit of any selection of practitioners,*‡ but give every registered

*For some interesting observations on the relative proportion of time devoted to panel and private practice and the relative income derived from each, see "Observations made on behalf of the Government on the Case presented to the Arbitrators on behalf of the Insurance Practitioners," *British Medical Journal*, March 6, 1920, p. 58 *et seq.* These calculations are extremely involved, but they indicate theoretical assumptions of average earnings in excess of the probable corresponding earnings in the United States. Unfortunately there is the same dearth of information regarding medical incomes for this country as for Great Britain. There is the further error of assuming an average income and an average panel as a proper solution of a difficulty which in its final analysis is primarily one of individual needs. The same fallacy applies to the capitation payment for medical attendance. No statistical averages can ever solve the problem of adequate medical attention, including drugs, etc., however much a semblance of order in normal frequency distribution may be presented by data derived from large experience.

†This statement should be read by all who desire a full understanding of the controversy, together with the memorandum by the president of the British Medical Association, February 28, 1920, and the report of proceedings with the award of the arbitrators, March 13, 1920.

‡In a recent debate on the amendment to the national health insurance bill which became a law on May 20, 1920, Dr. Addison, the Minister of Health, is reported to have said that "no man is asked to come on to the panel and that therefore he has no grievance if the Minister strikes his name off." (*Medical World*, June 4, 1920.) In the same issue of the *Medical World* in a discussion of the new

practitioner a statutory right to take part in the work of the service, unless and until his continuance be found, as the result of a public inquiry, to be prejudicial to the efficiency of the service.

"The Government desire the rate of remuneration, as well as other conditions of service to be such as will attract to the work (as they have in fact in the past seven years been able to attract) general practitioners who will not only give good service, but will cooperate in promoting improved developments of the service. But it would be visionary and wasteful to base calculations on the assumption that the service would be of a high ideal type throughout. The remuneration of the practitioners throughout Great Britain under the Insurance Acts for treatment (apart from drugs and maternity services covered by the maternity benefit) amounts, at 7s. 3d., to about £5,000,000; each additional 1s. represents £703,000; and doubling the capitation fee, as is in effect proposed in the Case, means a total charge of £10,000,000. The present financial position of the country precludes additional expenditure in respect of potentialities of service that are not to become realities within the immediate future, which alone is now in question."

Principles of Medical Remuneration

The foregoing statement has been given in full on account of its intrinsic value in all discussions having reference to the problem of medical remuneration.* The most important conclusion is that each additional 1s. of capitation compensation represents approximately £700,000. By reducing the claim of the British Medical Association of 13s. 6d. to its original concession of 11s. the government saved annually the substantial sum of £1,750,000, or, at the pre-war rate of exchange, about $8,505,000. This statement need only be set forth to emphasize the enormous sums involved in discussions of this kind, which must needs approach more and more to the status of a question in practical politics than of equitable consideration of the practitioner and fairness to the insured population.†

Passing over the discussion on the part of the government of the method of arriving at a principle of fair remuneration, and the arguments advanced with reference to the cost of living, it may not be out of place to include the following extended observations on the civil service award, or war bonus, and increased practice expenses:

"The amount awarded by the Civil Service Arbitrators in the case of a civil servant with a pre-war income of £800, the figure used as represent-

*For a full discussion of the statistical calculations to determine the proper rate of remuneration see the *British Medical Journal* of September 24, 1920, pp. 80-85.

†*British Medical Journal*, January 12, 1920, p. 808.

regulations, by Mr. Sidney G. Davis, it is properly said that, "a large number of medical practitioners, therefore, had practically no option but to accept service." The inclusion of 14,000 names in the panel service practically precludes an opportunity for gaining a livelihood in the case of a large number of young physicians who with a curtailed private practice would find it impossible to succeed without a panel. Under such conditions it is of the essence of cruelty to say that men professionally educated for a particular pursuit retain freedom of choice as to whether they wish to serve or not.

ing a doctor's income in paragraph 9 of the Case, is £300, or thirty-seven and one-half per cent.

"Practice expenses are stated to have increased by seventy-five per cent., and, on the assumption that practice expenses were one-sixth of the receipts, this would justify an increase in that fraction of the insurance receipts by seventy-five per cent.

"If five-sixths of the insurance receipts (in other words, the net income) is increased by thirty-seven and one-half per cent. and one-sixth of the insurance receipts (in other words, the practice expenses) is increased by seventy-five per cent., the effect on the whole capitation fee would be an increase of about forty-four per cent.; and forty-four per cent. of 7s. 3d. is about 3s. 2d., which would raise the sum of 7s. 3d. to 10s. 5d.

"It will be noted that the Case, so far as expenses of practice are concerned, rests largely on figures furnished for a limited number of rural and semi-rural practices, and that a very large part of the expenses consists of traveling expenses, which are obviously much heavier in rural than in urban areas. It is stated in paragraph 12 (c) of the Case that if figures could be obtained from urban areas certain results would appear. Considering the long period over which negotiations have extended, and the importance of this factor whether under the First or Second Methods in the Case, it is difficult to understand why the figures for a large number of urban practices have not been produced.

"If, however, for the purpose of argument, the estimate of increased practice expenses and the cost of living remains at forty-four per cent., the figure of 10s. 5d. must be subjected to a correction. It includes traveling expenses in rural and semi-rural, as well as in urban, areas. It therefore covers certain services, formerly covered by the 7s. 3d., which are now made the subject of a separate payment out of the Central Mileage Fund, equivalent to a capitation fee of 5d. for the whole insured population. This 5d. must be deducted from the sum of 10s. 5d., leaving a net sum of 10s."

This award, of course, came to an end with the new terms of remuneration, but approximately the bonus amounted to 1s. per capita, or in round figures to not less than £703,000.

Effect of the War on Sickness Experience

The war bonus was allowed largely if not exclusively on the ground of increased practice expenses. Full consideration of the bonus question would make an interesting contribution to the controversy; but, in brief, the principle adopted was as much a matter of political expediency at the time as seems to have been the case in the later consideration of the new terms of remuneration.*

*It would make an interesting contribution to knowledge if a thorough inquiry were made into the original calculations as to the cost of national health insurance and the actual results in the light of seven years' experience. It was estimated by the actuaries in charge of the calculations in 1911 that the

It is also important to consider in some detail the effect of war conditions on the health of invalided and demobilized men as well as on the population at large in its bearings upon the increasing demands upon the medical profession. The argument advanced by the government that "no case for an increase of remuneration has been made out" on this account, cannot be accepted. It is only necessary to refer to the admirable address by Mr. A. C. Thompson, the chairman of the National Conference of Industrial Assurance Approved Societies, who on October 29, 1919, brought the facts of actual experience to the attention of the public. It was shown that for the whole of three selected periods, or, respectively, 1916, 1917, and 1918, "that before enlistment the average duration of sickness benefit was 6.3 days per annum, and of disablement benefit 0.4 days per annum, whereas, after discharge, the duration of sickness benefit was 15.7 days per annum and of disablement benefit 3.2 days per annum. After discharge, therefore, the sickness benefit rate was two and one-half times the pre-enlistment rate and the disablement benefit rate was eight times the pre-enlistment rate." This experience, which is representative of national health insurance subsequent to the war, clearly emphasizes the increased burdens upon the medical profession for which no proper allowance was made in the calculations concerning a more adequate rate of remuneration.

Methods of Calculation

(24) Summarizing the considerations discussed as regards a method of calculation by which a fair compromise could be arrived at, the case is presented by the government in the following form:

"*(a)* That the original figure of 7s. 3d. was experimental—has not yet been investigated by reference to the services actually rendered—and was in excess of the actual earnings of the profession at the time when it was granted;

"*(b)* That if the basic figure proper to the pre-war conditions could be ascertained, the allowance to be made in respect of increased cost of living and increased expenses of practice should not exceed forty-four per cent. of that figure;

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rates of contribution necessary to provide the benefits would be, for men, 1.51d. for medical benefit; 0.32d. for sanatorium benefit; 2.39d. for sickness benefit; 0.78d. for disablement benefit, and 0.66d. for maternity benefit. The latter, of course, refers to wives of insured male wage-earners who are automatically included in the act. For women the weekly cost of the five different benefits was estimated at 1.51d. for medical benefit; 0.32d. for sanatorium benefit; 1.74d. for sickness benefit; 0.81d. for disablement benefit, and 0.17d. for maternity benefit. Combining these charges, the total cost of benefits was placed at 5.66d. per week for men and 4.55d. per week for women. In addition thereto the cost of administration was placed at 0.92d. for each sex, so that the total cost of the insurance was placed respectively at 6.58d. per week for men and 5.47d. per week for women. This would bring the estimated cost within the 7d. per week paid by men and the 6d. per week paid by women (representing contributions of both employers and employees). In addition thereto, however, the state grants a subsidy of two-ninths of whatever amount may be payable in benefits, giving rise to the expression "9d. for 4d.," the latter being the contribution paid by male wage-earners previous to the act of 1920, when the contributions were raised to 7d. for men and 6d. for women, or 10d. and 9d. respectively, including the contribution of 3d. on the part of the employers. The state subsidy of two-ninths to the claim payments remains the same. It would be difficult to conceive of a more complicated and involved system of accountancy and one at the same time less readily admitting of a satisfactory analysis.

"*(c)* That the available evidence tends to show that the amount of work required today of insurance practitioners per insured person is more likely to have been diminished by the collective results of war conditions than to have been increased;

"*(d)* That changes made in the conditions of service by the new Regulations will not have increased the services which practitioners previously contracted to give, to a degree represented by more than a nominal increase in remuneration;

"*(e)* That the considerations advanced in the Case in reference to changed conditions as regards public health and research, so far as they are not already covered, are not relevant to this Arbitration; and

"*(f)* That therefore no case has been made out for a net increase of remuneration (after allowing for the additional remuneration already provided under the Central Mileage Fund in respect of services previously included in the 7s. 3d.) which would involve the payment of a higher capitation fee than 10s."

Remuneration and the Cost of Living

On this basis, it will be observed, the government arrived at a minimum basis of compensation of 10s. against the 13s. 6d. asked for by the medical profession. Subsequently, however, in further calculations, the government took into consideration the measurement of the doctor's whole time income upon a time basis. This argument reads as follows:

"As regards the working expenses, the illustration based on the experience of several practices, given at the end of Professor Bowley's Memorandum, shows that practice expenses of £65 out of gross receipts of £400 became £113 out of gross receipts of about £620. The latter figure of expenses is about eighteen per cent. of the gross receipts.

"It is, however, recognized that Professor Bowley assumes an increase of net remuneration by fifty to fifty-three per cent., and that if this increase is limited to thirty-seven and one-half per cent., as proposed earlier in this statement, the expenses would be represented in Professor Bowley's illustration by twenty-two per cent. of present-day receipts. In view of this, and, making allowance for the fact that, for the present purpose, the special burden of the cost of traveling in rural areas and the cost of drugs everywhere, have to be excluded in measuring a doctor's expenses, a general average of twenty-five per cent. is considered to be a reasonable estimate of the proportion of gross receipts absorbed in the other expenses of insurance practice.

"With regard to the 'time factor,' objection must be taken to the contention that the conscientious care by an insurance practitioner of his insured patients will make it necessary for him to devote so much as

three-eighths of his total working time to the medical attendance and treatment (and ancillary duties as regards correspondence, etc.), which the responsibility for a thousand insured persons, well and ill, would involve. Such estimate appears to be based on the assumption of an ideal standard of service which it is not suggested exists in ordinary general practice."

In the foregoing calculation a table of percentages was made use of, according to which all the activities of the doctor were reduced to a proportionate time basis. It is not clear from what source the actual figures were arrived at, but the data utilized were for the year 1918, it being stated that home visits required 15.7 per cent. of the doctor's time; office attendances, 72.4 per cent.; special visits, 0.3 per cent.; night visits, 0.1 per cent; operations, anaesthetics, fractures and dislocations, 0.05 per cent.; and the making of reports and filling out of certificates, 11.4 per cent. The foregoing once more illustrates the method followed in trade union disputes on a wage basis rather than professional consideration resting upon compensation by fee. It was argued that, approximately, a panel of one thousand persons would take up two-sevenths of a doctor's working time, and on a 10s. capitation basis this would result in a gross income of £500, or £375 net (allowing twenty-five per cent. for practice expenses). If this amount were earned from the panel the net income from this and other sources on a full time basis would be £1,300 per annum. But all of this is mere conjecture, and no arguments are advanced to substantiate the theoretical assumption by an appeal to the facts of actual experience.*

The Award and the Medical Profession

(25) In conclusion, therefore, it was urged by the government "that, whether the question be approached by the first or second method of calculation, there is adequate ground for holding that a capitation fee of 10s. a head would provide 'fair remuneration' within the terms of reference of the Board." In due consideration of other elements of the problem the government, however, decided to offer a settlement on the basis of 11s., or the original offer made to the Insurance Acts Committee of the British Medical Association.

(26) The award of the arbitrators was published in the supplement to the *British Medical Journal* in the issue of March 13, 1920, with a full report of the proceedings, a document of nearly ten closely printed pages. This argument is another notable contribution to the literature of national health insurance, with particular reference to the question of medical practice. The award has been accepted in good faith by the British medical profession, in accordance with the agreement,† and it

*See *British Medical Journal*, March 12, 1920, p. 74.

†Of exceptional importance in this connection is Dr. Brackenbury's article on "Some Thoughts on Arbitration," the *Lancet*, March 13, 1920.

will be sufficient to quote the concluding remarks of Dr. Brackenbury with reference to the time for which the award will be supposed to stand:

"That the doctors' representatives would regard with disfavour any doctor who did not adhere to the award and gave three months' notice immediately after its appearance, and that on their side they would accept the award as operating for a year at least." He repeated that "there was at this moment a more eager desire on the part of the profession to give a good service than any of them had ever known within the profession before, but that of course to secure that service it must be adequately paid for and the doctors' case suggested in their view the right amount." The government representatives on their part emphasized their desire that a good service should be forthcoming, and said that it was essential from the public point of view that a good service should be secured.

How far this point of view is shared by the British medical profession remains to be seen. Of interest in this connection, however, is the following letter by Dr. Philip L. Benson, of Steeple Claydon Bucks (supplement to the *British Medical Journal*, March 20, 1920):

"I see that the arbitrators have unanimously decided in favour of the Government that the insurance capitation fee should stand at 11s., and not be increased to 13s. 6d. as the doctors claimed. Well the award has gone against us, and, though we are not satisfied with it, we must loyally accept it and do our best to give a good and satisfactory service to those insured persons who are on our lists.*

"It will not do for our profession, as other workers have done, to treat our engagements as scraps of paper, only to be carried out when in our favour; they must be looked upon as binding us honourably to perform what we have promised to do.

"I shall be very curious to know what the stalwarts of the Medico-Political Union will do under the circumstances, and how the 'men of Kent,' of Southhampton, and of York will act. Will they carry out the orders of headquarters and strike, or will they quietly accept the 'filthy' lucre,' and, like Brer Rabbit, 'say nuffin'? I wonder.

"At any rate, I am sure that the great majority of the profession will accept service, and will do their best for all those who are on their panels. We, sir, who have any sense of gratitude, must at the same time thank the Insurance Acts Committee of the British Medical Association for the great and unceasing help which they have given not only to their fellow members but to the profession at large."

*This will probably hold true for the majority of the profession, but a strong feeling of dissatisfaction must needs react unfavorably upon panel practice. It is said, for illustration, in an editorial in the *Medical World*, for January 16, 1920: "We warn the public that any whittling down of this questionable figure of 13s. 6d. means less and less efficiency," for, it is said, "the 13s. 6d. of the National Insurance Act is absolutely inadequate to guarantee efficiency." Yet the actual capitation fee paid for the year 1920 will only be 11s.!

The Award and the Rural Practitioner

(27) Much to the same effect is a letter with reference to the rural mileage grant, by Dr. J. Henry Stormont, in the supplement to the *British Medical Journal* of March 27, 1920, reading in part:

"I think every rural panel doctor will have learnt with some dismay that the arbitrators' award is 11s. per head, and drawn cold comfort from the promise of mileage fees sufficient to balance the difference in cost between urban and rural panel work.

"I am keeping records of mileage and of the number of visits to private and panel patients in my rural practice for the Ministry of Health. After reducing the number of my index cards by fifteen per cent., the least average of inflation in the two county areas in which my practice lies, I find that the annual cost in mileage of each patient on my list is 1s. 4 1/3d. per head taking all together, far and near."

The Award and the Insurance Acts Committee

(28) The subject is also discussed at some length in the annual report of the Council of the British Medical Association, published in the supplement to the *British Medical Journal,* April 24, 1920. Of exceptional importance is the reference to the distribution of the central pool and the mileage grant, but as to both of which much additional information will have to be forthcoming before the details are fully within the understanding of all concerned.

In concluding this rather extended review of the proceedings by which the present agreement between the British medical profession and the government on the question of remuneration has been arrived at, it may not be out of place to quote from an address "On the General Practitioner and the Health Services,"* by Dr. H. B. Brackenbury, the chairman of the Insurance Acts Committee, reported in the supplement to the *British Medical Journal,* May 15, 1920. Dr. Brackenbury said in part:

"By the public health services they were beginning to mean not merely the services they had been accustomed to consider in the past as belonging to the sphere of preventive medicine, but all State-organized and supported services which had to do with the health of the community." In view of the foregoing, he suggested that "it was of vast importance that the whole mind of the profession should be brought to bear upon the report, because it would gravely affect the future development of the public services and the relation of various interests thereto," for, he explained, "more and more the general practitioner was being taken out of what had been his almost traditional isolation, and was coming

*As elsewhere pointed out there is much dissatisfaction with the results of the arbitration, and while the present agreement has been accepted in good faith, it is not likely to be of long duration and it will probably not extend far beyond January 1, 1921, when the whole question will once more form the subject of extended negotiations.

more and more into touch with his fellow practitioners and with the various administrative appointments made by the State."

These considerations are made to rest upon the argument, "that the practitioner was the essential agent in any complete public health service, and that domiciliary attendance and treatment was the only foundation on which the systematic provision of other kinds of treatment could properly be based."

The General Practitioner and the Public Health Service

But it may be said to the contrary that the medical practitioner has not received the required education for the practice of preventive medicine in the modern and accepted sense of the term, although it is true, as pointed out by Dr. Brackenbury, that "no public health service, preventive or clinical, could possibly get on without the practitioner's full cooperation, and the first thing that the State had to do was to provide general practitioner treatment for those persons who were unable to provide for themselves, before it could with propriety set up any other services of a different type wanting specialist attention or residential attention, of which the public might be allowed to take advantage."

The foregoing argument is sustained by the further explanation, which is in conformity to modern conceptions of preventive medicine, that "they had not merely to prevent a healthy body deteriorating and acquiring disease, but they must help in keeping a healthy body up to the height of its possibilities."

But Dr. Brackenbury failed to draw attention to the fact that for such services the general practitioner is neither educated nor trained, not even in the most advanced medical schools of the present time, if, in fact, such education would not make the best training for the practice of medicine as a healing art difficult and perhaps impossible.

National Health Insurance and Preventive Medicine

These observations are merely preliminary to the broader question as to how far national health insurance can possibly be made to serve the interests of preventive medicine in the modern and accepted sense of the term: for *the prevention of death from disease or the prevention of a fatal termination of an existing disease is not equivalent to the prevention of illness occurrence or the conservation of health and life to a maximum degree of industrial and social efficiency.*

The fact is often overlooked that the enactment of national health insurance in Great Britain was made to rest upon the claim that the system would materially aid in the prevention of disease and bring about in course of time a material lowering of the death rate.* The war has naturally resulted in disturbed conditions which make an exact comparison

*The preamble to the act of 1911 reads that the object of national health insurance is "to provide for insurance against loss of health and for the prevention and cure of sickness." To provide monetary compensation in the event of sickness occurrence or medical treatment on account thereof, is not "to provide for insurance against loss of health."

of the present with the past a matter of much difficulty. But regardless of the conflict of evidence it may be asserted without fear of contradiction that in the broader sense national health insurance during the nearly eight years of its operation has not directly contributed towards this end in view. I cannot do better than quote the views of the Grand Master of the Order of Druids, one of the most important friendly societies, as set forth at the sixty-second annual meeting of the society on May 25, 1920, stating that "although friendly societies have been administering the national health insurance act for nearly eight years, it can not be said that the health of the people has been improved even in the slightest degree by the provisions of the act. Sanitarium treatment has proved more or less a failure; there is an entirely inadequate and unsatisfactory medical service; and the duties of the approved societies have been wholly confined to administering cash benefits."

Equally suggestive is a resolution adopted at the eighth annual conference of the National Health Convention of the Association of Approved Societies, held at the Workmen's Club and Institute Hall. According to a report in the London *Times*, of April 16, 1920, "the time has come when the panel system in all public health service should be substituted by a comprehensive State Medical Service, securing to the whole population at national expense the most efficient and complete service that medical, surgical and dental science can offer."*

The New Medical Benefit Regulations

The task confronting the government is, however, most formidable if not hopeless. This is best illustrated by the recently promulgated medical benefit regulations, 1920, made in continuation of previous regulations in behalf of the effort to secure a more satisfactory method of medical administration. The tendency is strongly in the direction of increased complexity, for while the medical benefit regulations of 1914 were contained in thirty-three sub-sections, the revised regulations constitute a code of some seventy general rules, amplified by schedules and appendices making in the aggregate a volume of more than fifty closely printed pages. It may serve a useful purpose to briefly review these rules and regulations, if only to illustrate, in part, the administrative burdens imposed upon a *quasi* state service, in contrast to the simplicity and the freedom of action inherent in any system of private practice.

The general rules commence with the terms of service, the medical list, the drug administration, and regulations governing persons required or allowed to make their own arrangements. These are followed by an extended series of rules governing the method of obtaining medical benefit, from the selection of the practitioner and the allocation scheme to the change of a practitioner, cases of removal from a district, etc.

*See pages 88-90.

Rules Governing the General Practitioner

The financial provisions are equally extended, beginning with the central practitioners' and mileage funds and the distribution committee,* and continuing to the practitioners' and mileage funds, the drug fund, and payment to institutions. A subsequent section is limited to provisions relating to investigations, disputes, appeals, etc., including observations on the constitution of medical service sub-committees, and investigations by such committees, the rules of procedure, etc. Included in this section are the rules governing the constitution of pharmaceutical service sub-committees, investigations by such committees, rules concerning joint services sub-committees, appeals to the Minister, procedure on appeals, or procedure on withholding a parliamentary grant. Included also are important rules governing investigations as to excessive prescribing, and decisions as to the range of medical services and the duty of local medical committees to consider complaints.

The rules governing inquiries relating to practitioners are equally elaborate and indicative of the highly technical character of such investigations, as must necessarily be the case, considering the often confidential relations of a practitioner to his patient. This section includes twenty-four sub-divisions, including the rules of procedure regarding inquiries, the power to postpone an inquiry and the right of application for arbitration under the arbitration act of 1889. Reference may be made in this connection to a suggestive discussion of a panel doctor's action for slander reported in the *Lancet*, March 20, 1920 (p. 676), as an indication of the difficulties which are likely to arise under a rigorous enforcement of the regulations.

Rules Governing the Drug Trade

Inquiries relating to persons supplying drugs or appliances can not be dealt with in detail, although the subject is one of considerable controversy, as made evident by the report of a special parliamentary committee on the administration of the drug clauses of the national health insurance act.† I hope to be able some time in the future to present in some detail the highly involved relations which have developed between the pharmaceutical profession and the medical profession on the one hand and the state on the other. The establishment of drug pricing committees has practically become universal throughout England and Scotland, but it requires to be kept in mind that the objective of such committees is primarily economic, that is, the protection of the insurance

*A so-called "clearing-house," was established by the government for the purpose of correcting errors and the elimination of duplication. This office, which employs quite a clerical force has not yet made a report, but its operations have unquestionably been of much value in behalf of the simplification of the index registers and the necessary reduction of inflated panels.

†The title of this publication is "The Report of the Parliamentary Committee Appointed to Consider the Conditions Imposed by Section 15 of the National Health Insurance Act of 1911 on the Supplying of Medicine to Insured Persons," Vol. 1, Cd. 6853, London, 1913, price 2½d. Vol. 2, Minutes of Evidence, Cd. 8063, London, 1915, price, 2s. Obtainable through P. S. King & Son, Great Smith Street, London.

fund against imposition and fraud.* Cases of over-prescribing are frequently punished with considerable severity, and there has developed a tendency to under-prescribing rather than incur the risk of prosecution.

Rules Governing the Treatment of Patients

The terms of service for practitioners are reprinted in full in the Appendix marked "A," for convenient further reference. These terms should be read by all who desire to obtain a full understanding of the highly involved nature of the relations which are now a matter of statutory regulation between the medical profession and the state. Of special importance are the arrangements for practice on retirement or at death and the rules governing the class of persons for whose treatment the practitioner is responsible. As a matter of more convenient consideration these terms are given below:

"The persons for whose treatment the practitioner is responsible are:

"*(a)* All persons who have been accepted by him for inclusion in his list and who have not been notified to him by the Committee as having ceased to be on his list.

"*(b)* All persons who have been assigned to him in accordance with the Allocation Scheme and who have not been notified to him by the Committee as having ceased to be on his list.

"*(c)* All persons for whom he may under the terms of the said Scheme be required to provide treatment pending their acceptance by or assignment to a practitioner, or to provide treatment in case of accident or other sudden emergency."

Among other matters in the rules are references to the acceptance of fees, the employment of deputies, assistants and partners, the possibilities of disputes and appeals, and, finally, the power of the Minister to suspend the system, which practically gives the Minister of Health autocratic control over the practitioners' services in particular localities.

The second portion of the terms refers to the method of remuneration, as follows:

"*(a)* A capitation system, that is to say, payment by reference to the number of insured persons included in the practitioner's list.

*The discontent in the pharmaceutical profession with the remuneration paid at the present time is reflected in the following statement as given in the *Foresters' Miscellany*, January, 1920, p. 5: "All the panel chemists in Ayr have tendered their resignations to the Burgh Insurance Committee. The chemists demand an increase of 50 per cent. on the Scottish scale of dispensing fees. The Insurance Committee have decided to intimate their resignations to the Board of Health, stating that in their opinion an immediate settlement with the chemists should be made. The chemists of Dumbarton and Arbroath (Forfarshire) have also given notice of resignation. Up to the time of going to press we have not learned the terms of settlement." Additional to the foregoing, it is said in a subsequent issue of the same publication that "the panel chemists have agreed to accept the offer of the National Insurance Commissioners for Scotland to an increase on the basis of 5½d. instead of 3d., or, in other words, an additional sum of 2s. per 100 prescriptions."

"*(b)* An attendance system, that is to say, payment by reference to the attendances given and services rendered by a practitioner to insured persons.

"*(c)* A combined system, that is to say, payment by capitation except in respect of special classes of service for which payment is made by reference to the services actually rendered.

"*(d)* Such other combination or modification of the above-mentioned systems, or any of them, as the Minister may approve."

Methods of Payment

The involved nature of the proposed arrangement and the practical difficulties of exact justice to the medical practitioner are further illustrated in the following rules governing the method of remuneration in the calculation of the amounts due for services rendered:

"*(a)* The calculation of practitioners' lists.

"*(b)* Payment for the services of a practitioner administering an anaesthetic, and power for the Panel Committee to examine and disallow accounts for such services, subject to the practitioner's right of appeal to the Minister.

"*(c)* Payment for treatment given by a practitioner in an emergency to an insured person for whose treatment another practitioner is responsible.

"*(d)* Payment in respect of temporary residents.

"*(e)* Adjustment of payment in the case of a practitioner who is exempted from the liability of having insured persons assigned to him.

"*(f)* The method of charging to the Practitioners' Fund any sums allotted by the Insurance Committee to, and for the administrative expenses of, the Panel Committee.

"*(g)* The method by which and time within which the distribution of the Practitioners' Fund is to be made.

"*(h)* Payment in the case of partnerships.

"*(i)* Payment to practitioners in respect of the supply of drugs and appliances.

"*(j)* Payment in respect of mileage.

"*(k)* The issue at the end of each year by the Committee to each practitioner of a statement, in a form approved by the Minister, showing the amounts credited to the Practitioners' Fund and the Mileage Fund for

the year, and the method by which the practitioners' shares, if any, of those funds has been calculated.

"*(l)* Such other matters, if any, as the method adopted may require."

Included in the appendices are the forms of application for admission to medical lists (B) and the medical certification rules, which are quite extended and a source of much controversy in important matters of detail. Finally, there are included copies of certificates for incapacity for work, as required by law, which constitute the underlying consideration for the payment of medical benefits. (Appendix F.)

Pharmaceutical Service

Although a discussion of the drug administration under national health insurance does not fall within the scope of this address, as a matter of convenient reference, there is included a full statement of the provisions relating to persons, firms or corporations entitled to carry on the business of chemist or druggist under the provisions of the pharmacy act and who undertake to supply both drugs and appliances under the national health insurance acts of 1911 and 1920 (Appendix B). To make this record complete, there is also included a form of application for admission to the list of persons supplying drugs and appliances (Appendix C); and finally a schedule of such appliances (Appendix D), which makes clear the extremely limited range of the service rendered under the act in important particulars, which would not be permissible under any rational method of poor law administration.

An important question in national health insurance is the special provision made regarding persons required or allowed to make their own arrangements for obtaining medical benefit. This group of persons is not large, but relatively important in that it constitutes a group more or less within the range of the work of private practitioners. The details governing this provision of the law are given in full in Appendix E.

Panel Patients and Non-Panel Doctors

In this connection it would be desirable to consider in some detail the question as to the extent to which panel patients make use of non-panel doctors for the purpose of securing a more satisfactory mode of treatment in cases of serious or prolonged illness. The evidence on this point is conflicting, but sufficient for the purpose to justify the conclusion that a very considerable amount of discontent exists which has not been removed, nor is it likely to be done away with by the new regulations.

Dissatisfaction with Panel Practice

An actual case of dissatisfaction with panel practice may serve a useful purpose. The following is a verbatim copy of a report made by the medical service sub-committee of the West Ham Insurance Committee,

bearing the date of March 31, 1920. The report is given in full, not only on account of the importance of the case, but as an illustration of the method of procedure followed:

"1. They have had under careful consideration question No. 69 raised by an insured person as to the medical attendance and treatment provided by an insurance practitioner. The statement submitted by the complainant appeared to embrace two separate and distinct questions, viz.:

"*(a)* Alleged refusal by the insurance practitioner to provide complainant either the treatment to which he was entitled as an insured person, and

(b) Alleged inadequacy of the insurance practitioner's surgery accommodation, and your sub-committee addressed themselves to the investigation accordingly. Having interviewed the complainant, the practitioner and his two witnesses, and two representatives of the complainant's approved society they find with regard to question *(a)* that

"*(i)* The insured person attended the insurance practitioner's surgery for treatment of a slight cold, for which the insurance practitioner prescribed a Tr. Camph. Co. and Vin. Ipecac mixture and instructed the patient to remain in bed for a day or two;

"*(ii)* About a week later the insured person again attended the practitioner's surgery, demanded more effective medicine and suggested that had the medicine prescribed previously been as good as that provided when he was treated as the private patient his recovery had been more speedy;

"*(iii)* The insurance practitioner repudiated the inference that the treatment given by him to insured persons differed from that given to private patients, and suggested that if the insured person required to change his doctor he should apply to the Insurance Committee, whose address would be found on the medical card. The insured person thereupon left the surgery and applied to another practitioner for the treatment immediately required by him;

"*(iv)* The insured person admitted that he did not remain in bed, and stated that the practitioner did not advise him to do so. The insurance practitioner expressed the view that had his instructions in this direction been carried out a more speedy recovery would have followed.

"Your sub-committee are not satisfied from the evidence before them that the complaint of refusal to provide treatment is well founded. Doubtless the discussion between the insurance practitioner and the insured person upon the occasion under review was accompanied by some feeling which caused the insured person to leave the surgery before the

practitioner had an opportunity of giving him treatment. Under these circumstances they recommend that no further action be taken in the matter beyond allowing the insured person to exercise a fresh choice of practitioner.

"With regard to question *(b)*, viz., the alleged inadequacy of the practitioner's surgery accommodation, the insured person stated that notwithstanding that a large number of persons were, upon the occasion under review, awaiting attention, the accommodation was exceedingly small and only four chairs were available for use. He further alleged that the practitioner's consulting room was divided off from the waiting room by means of a drawn curtain only and that persons awaiting attention could hear and sometimes see the doctor in consultation with his patients. The practitioner submitted a drawing showing the positions of his waiting and consulting rooms which to some extent proved the insured person's statement to be correct. It would seem however that two of the ground floor rooms of the house are devoted to the practice requirements. The first nearest the entrance hall being divided into three sections, viz.: (1) waiting section (2) section for first consultations and examination and treatment of simple ailments, and (3) dispensary section. The two former sections are divided off by a curtain reaching from the floor to about two feet from the ceiling, while the latter section is divided off by a wooden partition of dimensions similar to those of the curtain. The second room is used as an inner consulting room for the more careful and exhaustive examination of patients needing it.

"Your sub-committee consider that these arrangements are wholly unsatisfactory involving as they do not only considerable curtailment in the waiting-room accommodation but absence of complete privacy of consultations. They think that this privacy should be assured to each patient whatever the nature of the patient's ailment and the consequent investigations by the doctor may be; and they recommend that the practitioner be requested to arrange that the whole of the first room be availiable as a waiting-room, and that the second room be used for all consultations."

Such inquiries into the actual details of panel practice are naturally most difficult and time-consuming. For the purpose of ascertaining the collective view-point of the British medical profession on this and related questions a questionnaire was sent out to a large number of panel and non-panel practitioners, of which the following may be accepted as a compromise of widely conflicting views. The reply was prepared by an experienced panel practitioner at the request of a leading member of the British medical profession who was good enough to cooperate in this investigation.

Views of an Experienced Panel Practitioner

"A. Does the act, from the practitioner's point of view and in a general way, meet the reasonable requirements of the wage-earning elements of Great Britain?

*"The national insurance act upset the 'reasonable requirements' of the wage-earning class provided by the voluntary hospitals, when beyond the range of the general practitioner, without making any provision of a like nature in compensation. State-aided persons (like the insured) cease to have any claim upon the voluntary hospital and many employers discontinued their subscriptions to voluntary hospitals when compelled to pay towards the insurance of the employee.**

"B. Is the administration of medical benefits generally satisfactory and actually of curative value in the majority of cases, or, to the contrary, rather in the nature of only temporary alleviation and relief?

"This depends entirely on the honesty, energy and resources of the panel doctor, since there is no 'medical benefit' under the acts beyond that supplied by him.

"C. Are you aware of any cases of wrongful discrimination in favor of private patients as opposed to the best interests and personal pride of panel patients?

"No honorable panel doctor would dream of making this distinction, but as his practice is subject to invasion by all sorts of undersirable insured persons, some discrimination may become necessary without being wrongful.

"D. Do you endorse the statement made by Dr. Wm. A. Brend that 'On the whole the standard of treatment among the insured class is no better than that which pervailed before the passing of the Act'?

"The 'standard of treatment' ultimately depends upon the capacity of the panel doctor and cannot be fixed by regulation under the act, 'free choice of doctor' being reserved to the insured, the question of a standard will remain as elusive as ever.

*The seriousness of the voluntary hospital problem throughout England and Scotland cannot be easily exaggerated. The subject is one of practically continuous discussion in the medical periodicals and in the *Hospital*, a technical publication devoted to administrative medicine and institutional life. At the same time, progress is being made in developing improved methods of hospital treatment, as best illustrated by an article in a recent issue of *Guy's Hospital Gazette*, in which there appears a very strong and eloquent plea for more careful consideration of the patient "with symptoms but no physical signs," in the words of the medical correspondent of the London *Times* (June 16, 1920), who goes on to say, "Most important of all, the physician in charge of this new department would accumulate material illustrating how often patients with symptoms and no signs develop definite organic disease while under treatment . . . and it seems possible that a careful study of those patients with so-called functional disorders would result in our obtaining valuable information about the symptomatology of disease in its very earliest stages." This view is in entire harmony with the illuminating observations advanced by Sir James Mackenzie in "The Future of Medicine." See the *Lancet*, January 31, 1920, on the voluntary hospital system, and the London *Times*, June 18, 1920, on the same subject, with special reference to the view-point of the Ministry of Health. For additional observations on urgently needed reforms see a letter from S. G. Asher, London *Times*, May 7, 1920, and also a letter by Mr. John Murray, London *Times*, May 3, 1920. The whole question is summed up in the concise statement contained in a letter by Lord Knutsford, chairman of the London Hospital, on the financial crisis, dated May 27, 1920. Of special interest is an extended article on hospitals, by the medical correspondent of the *Times*, in the issue of May 1, 1920, with particular reference to reasearch, it being said that "it cannot be too often or too strongly insisted that the future of medicine lies not in the study of well-established disease *but rather in the study of disease before it becomes established at all.*"

"E. Do you consider the medical service rendered as 'adequate' in the ordinary sense of the term?

"*Absolutely,* No. *But relatively to the conditions of service and terms of remuneration,* Yes.

"F. Could you suggest a more concise and satisfactory definition of the term 'medical benefits' than is in vogue at the present time?

"*The condition of service, the terms of remuneration and the official attitude of the government towards the profession from the outset having been based on a valuation of medical practice* at its lowest,* *the present definition of 'medical benefit' can hardly be made more precise or satisfactory.*

"G. Do you endorse the statement made by Dr. Brend, that the prevailing definition of medical benefit is in the sense as laid down by the commissioners, that an insured person is entitled only to 'such treatment as is of a kind which can consistently with the best interests of the patient be properly undertaken by a practitioner of ordinary competence and skill'?

"*As applied to the panel doctor, Yes; but no scheme of national health insurance can be regarded as complete which omits hospital treatment and the services of experts. These ought to have been provided from the outset.*†

"H. Do you approve of the appointment of medical referees as essential to the purpose of preventing malingering or imposition otherwise under the act?

"*The panel doctor ought to welcome the appointment of such referees, provided that the referee be of consultant status and accustomed to giving due consideration to such data as can only be within the knowledge of the panel doctor.*

"I. Are you aware of any well defined tendency to malingering or undue prolongation of illness or feigned sickness?

"*It is not a common experience, because the sickness benefit hitherto has seldom provided enough temptation. It is apt to occur where the occupation is seasonal and not constant.*

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*In an article on "Freedom," in the *Medical World*, January 16, 1920 (p. 49), it is said: "Then came the National Insurance Act, which, by an unexampled act of thieving, robbed the doctor of a large slice of his private practice, putting it on the same bad old level as club practice. Then the Regulations, the framers of which, together with their medical-politician advisers, had several obsessions. They were convinced that Teutonic ideals and Teutonic methods alone were worth consideration. They were obsessed with the official idea that a 'System' must be set up; nay, more, that the Art of Healing, which one would have supposed to be of central importance to a National Health Act, must be made to fit the system, not the system fit the Art." Furthermore, it is said that "the panel practitioner is a bondsman in a double sense. He is a bondsman to the Commissioners. He is also a bondsman to the quarterly cheque. On this the Minister relies and bases his insolence." And that "the freedom of the medical profession has been of incredible value to the State in its past history. But what of the present? Panel doctors, Army doctors, and pensions doctors have largely to say only so much as they are allowed or told."

†These services have not been provided for under the amended law of 1920, nor is it at all likely that they will be forthcoming in connection with national health insurance within a measurable period of time.

"J. Do you endorse the statement made by Sir John Collie that thousands of employees which should be at work successfully claim sick pay'?

"This can seldom happen except when panel lists are overcrowded, and when individual attention becomes insufficient.

"K. Is the practice as revealed by the medical referee employed by the Ayrshire Insurance Committee of fairly common occurrence in your experience, it being stated that 'of the persons which were examined over thirty-nine per cent. were found fit to work, and if those who resumed work rather than go before the referee be included, the number found fit was increased over forty-seven per cent.'?

*"Such a sweeping statement would demand independent and competent corroboration before acceptance.**

"L. What are your views as to the feasibility and practical value of a state medical service?

"If a state medical service were introduced in Great Britain its ends would be defeasible—and defeated.

"M. What would be your reply to the question asked in the House of Commons on May 26, by Major Farquharson, as to whether it was intended 'to introduce a bill this session that would establish a new system of general medical service for the population, and if so, whether such a bill would provide a whole-time salary service including hospitals and clinics'?

"Few would be surprised by the introduction of any wild-cat scheme by a faction seeing its opportunity in the present state of flux, and many panel doctors believe that the existing acts form a piece of political kite-flying with an eye to a whole-time service for the entire population.

"N. Is the sanatorium benefit generally satisfactory?

"Yes, wherever the methods adopted are sound in theory and thorough in practice.

"O. What are your views on the domiciliary substitute for institutional treatment?

"For premonitory cases and for training and education in all early cases institutional treatment is alone valuable. Supervision of cases under domiciliary treatment must be worthless [unless] continuous, but whatever methods be adopted the patient tends to become restive and intolerant of control.

*The experience of the Ayrshire Insurance Committee is confirmed by medical referee reports of other sections of the United Kingdom and the extended German experience as shown in my address on the "Failure of German Compulsory Health Insurance." The urgency of more stringent supervision is emphasized by the recently adopted rules regarding state medical referees as a part of national health insurance administration. The annual report of the Aberdeen medical service sub-committee contains the statement that ninety-five persons were found to be fit for work against only fifty-six really in need of medical benefit and pecuniary assistance. Of course in all such cases a reasonable doubt may be said to exist, but it is safe to assume that the judgment of the examining physician would err rather on the side of the patient than the public.

"P. Are you aware of cases of undue delay or insufficient accommodation in the administration of sanatorium benefit?

"These are inevitable under existing conditions.

"Q. Has such benefit been of value in the furtherance of efforts to diminish the frequency of tuberculous diseases?

"Undoubtedly yes.

"R. Is there a direct relation of national health insurance to the prevention and control of occupational diseases?

"The data furnished for this purpose by the panel doctor's record cards may not have been utilized (as intended) by the national health insurance commission, but they would in any event be of no value when compared with the information collected by medical officers of health.

"S. Are you aware of any investigation having been made to determine the causes of an excessive local incidence of sickness and to remedy ascertained evils, if necessary by drastic action?

"I have not heard of any cases in which the powers reserved to the commission in this respect (Sec. 63) have been exercised.

"T. Are you satisfied with the provisions of the act as they apply to the administration of drugs and the public control of the drug supply?

*"There is no provision in the act for the 'public control' of the drug supply. Dispensing doctors and chemists invariably buy the most reliable drugs because in the long run they are the cheapest.**

"U. Is the work of the drug-pricing or checking committee satisfactory, or otherwise?

"As large staffs of accountants and clerks are employed and as every item and all statistics are elaborately worked out to two places of decimals the work done is at any rate costly.†

"V. Is the practice of using stock medicine frequently abused?

"The obvious aim in all contract practice being to get the patient well quickly, the abuse of 'stock medicine' may be regarded as chimerical.‡

*This statement is in conflict with the many expressions to the contrary in letters contributed to the *British Medical Journal*, emphasizing the pressure brought to bear upon doctors to practice rigorous economy in prescribing to avoid the risk of prosecution.

†It is doubtful whether this point can be maintained by an appeal to the actual facts of extended experience. From such investigations as I have made it would appear that the drug-pricing committees work both cheaply and economically, so much so that they have practically become indispensable to the administration of pharmaceutical benefit. Perhaps the most satisfactory experiment of this kind is the drug-pricing committee for Scotland, which has its offices in Glasgow. A comparatively small and underpaid staff of employees performs an astonishing amount of work of the utmost practical importance, for as long as the state is responsible for the cost of drug administration, the urgency of rigorous economy is obvious.

‡The abuse of stock medicine is not imaginary, but real. Stock prescriptions form an integral part of panel practice, standardized to the point of mediocrity. It must be self-evident that where the time factor is the chief consideration in treatment, stock medicine must be given the preference rather than prescriptions in conformity to the principles of pharmacy. For a list of "Standard Prescriptions for Insurance Practice," see a small treatise by this title, by C. H. Gunson, the Scientific Press, 28 Southampton Street, London. Practically every insurance committee issues a local pharmacopœia containing stock prescriptions. It may be said in this connection that stock medicines are not permissible in Scotland, where it is claimed that pharmaceutical practice is on a distinctly higher basis than in England and Wales.

"W. Is it true that expensive drugs are frequently eliminated for reasons of economy and to avoid the risk of over-prescribing?

"*Yes, that is one of the blots of the system. The* 'rare and refreshing fruit' *promised by W. Lloyd George, when he was ridiculing the club doctor and his stock mixtures, becomes* forbidden fruit *whenever the National Health Commission or any of its satellites can detect its consumption.*

"X. Is the quality of the drugs generally satisfactory?

"*Yes, certainly.*

"Y. Is not the present system of drug-pricing, checking, etc., both costly and burdensome alike to the practicing physician, the druggist, and the public?

"*Yes, an iniquitous system.**

"Z. Is the panel system satisfactory to the majority of patients?

"*The patients generally hate the system both for their own sakes and on behalf of the doctors who served them equally well under less galling conditions. Seven years' experience of the working of the act has in no way lessened their repugnance to the position of 'club' or 'contract' patients to which they consider themselves reduced by the act.*

"AA. Is there real freedom in the choice of physicians, and can changes be easily made when desirable and thought necessary by the patient?

"*Yes, changes can be made by giving a month's notice before 1st June or 1st December to the Insurance Committee, or immediately at any time by mutual consent, which is never withheld.*†

"BB. Is there any undue loss of time on the part of panel patients in the case of panel physicians with an unusually large practice?

"*This would be inevitable in any practice, panel or private, unless the doctor adopted means to limit his practice.*

"CC. Do you endorse the statement made by Dr. Brend that 'many practices are far too large'; and the statement attributed to Dr. Alfred Salter, speaking for himself, that he saw 'on an average seventy-six cases in the morning and ninety-two in the evening,' that the time factor worked out 'at three and one-quarter minutes for each patient, one and one-quarter minutes of which was taken up in writing,' and furthermore that 'cases had to wait on an average two and one-half hours for their turn unless present at the very start'?

"*These conditions need not occur.*‡

*This view, I am sure, has not the endorsement of the medical profession in the light of the last few years' experience, and no drug-pricing committee, once established, has, as far as I know, been discontinued.

†Real freedom of choice is not possible. Under the present regulations a patient cannot change his physician when he pleases, but he may do so only at stated periods, twice a year. To be real freedom of choice he should be at liberty to make the change desired whenever in his judgment it is advisable that he should do so.

‡It may be true that these conditions "need not occur," but that they are a matter of relatively common occurrence is made evident by Dr. Brend, in his "Health and the State" (New York, 1917).

"DD. Does the act, in your judgment, effectively reach the poorest poor, or, in other words, those most urgently in need of material assistance in illness and of qualified professional treatment and advice?

"*The greatest injustice under the act has been in the case of 'deposit contributors' whose health is too poor to enable them to enter an approved society and whose sickness benefit is limited to the amount of their balance on deposit.*

"*The 'poorest poor' are provided for under the poor law, but the number of their class requiring medical treatment as paupers has been considerably reduced by the sweep of the national health insurance net.*"*

A Proposed Public Medical Service

Since these replies were made the administration of sanatorium benefit has been removed from the national health insurance act, and been transferred to the public health authorities, except in Ireland. By taking this action the Ministry of Health clearly emphasizes the accuracy of the conclusion frequently advanced in the past that the administration of sanatorium benefit under national health insurance has not been productive of the results anticipated. What is true of sanatorium benefit is equally true of maternity benefit, and the time cannot be far distant when that benefit also will be removed from national health insurance and made a matter of more efficient administration under the provisions of the maternity and child welfare laws. Having removed sanatorium benefit from the provisions of the national health insurance acts, and it being likely that maternity benefit will be likewise removed in the future, there will remain only sickness benefit, or the payment of pecuniary compensation or relief during illness, and the administration of medical benefit. The latter, it may therefore be assumed, will also in course of time be removed and become a more strictly defined state function in conformity to the widespread demand for a state medical service.†

Nothing better illustrates the shortcomings of state medicine than the failure of the British government to meet adequately the needs of discharged soldiers and sailors lured by promises of extraordinary efforts in their behalf after the end of the war. The following article is from the London *Times* of July 29, bearing the title "Death While Awaiting Treatment," or "Pensions Staff Delay":

*As far as it is possible to judge, the number of poor persons in need of medical attendance is not diminishing under national health insurance, as shown in my address on the "Poor Law Aspects of National Health Insurance," Newark, 1920. If any reduction has been had it is probably limited to old-age pensioners, who formerly were cared for under the poor law. It is only too true at the present time that a considerable proportion of poor law medical cases are insurance cases both under outdoor relief and under institutional care.

†Of interest in this connection is a statement made at the quarterly meeting of the Midland Federation of Friendly Societies' Councils, held at Rushden and reported in the February issue of the *Foresters' Miscellany*, 1920, by the Honorary Secretary of the Federation, Bro. C. E. Hudson, who said in part, that "State medical service was sure to come, and the action of the doctors indicated that they at any rate realized this fact." In explanation as to what he meant by a state medical service he said, "The service should be open to all sufferers irrespective of their financial or social condition; the service should be so organized as to attract to the profession the best brains of the community; the scale of remuneration should be adequate to the importance of the service rendered; and there should be compensation for any disturbance of office and a reasonable pension on retirement," in other words, "a complete medical organization and a comprehensive scheme of nursing."

"In a written Parliamentary answer to Captain Loseby, who asked for the name of the official or officials responsible for dealing with the case of the disabled soldier at Farnham, which was referred to the Ministry of Pensions on May 22, but which had not been dealt with, in spite of innumerable requests, on July 3, when the soldier died, Major Tryon says:

" 'The provision of treatment in cases such as this of tuberculosis rests solely with the Ministry of Health, and I understand that the local committee brought this case to the knowledge of the Insurance Committee and the tuberculosis officer, in accordance with instructions at the end of May, and the treatment prescribed was provided early in June. The function of the Ministry of Pensions in this case was to assess the claim for pension under Article 9 of the Royal Warrant, and where necessary to authorize the payment of allowances during treatment by the special procedure applicable to cases of urgency.

" 'Unfortunately the local committee appears to have made the initial mistake of communicating with the Commissioner of Medical Services for the region instead of directly with the Deputy-Commissioner, who is resident in the district of the committee concerned, as they are instructed to do in cases of urgency. This led to confusion and to the case being treated as a claim for pension only. I am satisfied, however, that there was serious delay on the part of the regional staff in dealing with the case, and I am causing full inquiry to be made into the matter. I shall not hesitate to take disciplinary action when I have ascertained to whom responsibility for the delay is to be assigned.'

"History of the Case.—The following particulars of the case, which was reported in *The Times* of July 23, were given by Lieutenant-General Sir Edmond Elles at a recent meeting of the Surrey War Pensions Committee:

"May 22.—The case came before the Committee and a request was forwarded to the Ministry of Pensions that the case should be dealt with.

"June 4.—Further request was submitted that the man should be examined as early as possible.

"June 15.—A request for a reply to the two previous letters.

"June 17.—A further urgent request for a reply.

"June 29.—A request that the man be examined, as he was not expected to live.

"July 1.—A request for instructions by return of post.

"July 6.—The D.C.M.H., Guildford, visited the man and found him dead."

The foregoing is by no means the first emphatic protest in the British press. Of interest in this connection is an account from the London *Times* of the same date entitled "Bureaucracy Gone Mad," or the "Surrey Council's Protest Against Extravagance," reading as follows:

"At a meeting of the Surrey County Council at Kingston yesterday, the Finance Committee recommended that the Council strongly urge the Government to reduce the present undue strain on the resources of the country in respect of its public services, and in particular protest against the action of the various Government Departments in seeking to force expenditure upon the ratepayer which was likely to prove an intolerable burden.

"Lieutenant-General Sir Edmond Elles moved the adoption of the recommendation, and pointed to the way in which the county and local authorities were compelled to incur expenditure over which they had no control while the Government itself indulged in a riot of extravagance.

"Sir Arthur Chapman seconded, and as a member of the executive of the County Councils Association said they were constantly realizing the shameful extravagance that was being carried on by the various Departments of the Government. He had had special opportunities of finding out instances in which the Government had gone out of its way to create new offices. As an illustration of Government methods, he said most counties had a nursing association and highly trained ladies looking after the inspection of midwives, and the work was most efficiently done. Yet the Government now proposed to appoint three super-ladies to go about the country to inspect the county inspectresses. (Laughter.) That was an illustration of bureaucracy gone mad, and they should no longer submit to it. The same thing was going to be done in regard to agriculture.

"The motion was carried unanimously."

Yet the Llanelly Council unanimously advocates State pensions for women with more than two children, while the same announcement conveys the information that "thirty-two ex-soldier tramps have passed through the workhouse at Llanfyllinm, North Wales, this month."

Changed Conditions of Medical Practice

It is true that such a service is strongly opposed by the organized medical profession, but a number of organizations are making a persistent propaganda for such a service, and they have the influential support of trade unions and approved societies on the one hand and of the public health administration on the other.* It has properly been said in an editorial on "The State and Medicine," in the London *Times* of May 28, 1920, that "the relationship between the doctor and the State has been undergoing

*Of interest in this connection is the following statement contributed by the Scottish correspondent of the *Lancet* to the January 3, 1920, issue of that publication:

"At the annual meeting of the Medical Guild held in Edinburgh a discussion took place on the question of State Medical Service. In opening the discussion the chairman, Dr. John Playfair (Edinburgh), said that whether they liked it or not they would, there was little doubt, in the near future be faced with a State Medical Service. The Guild was quite ready to accept such a service if it were to be limited to the necessitous classes only, and, indeed, they would favour such a proposal. They feared, however, that the service proposed by the Government might be of much wider scope, and might ultimately embrace the whole community, including hospitals and all other institutions connected with the health of the community. This would tend to reduce all professional activities to a dead level, and would entirely abolish friendly feeling and sympathy between doctor and patient, and lead to inefficient medical attendance. It would emphasise and increase all the weaknesses and faults of the National Insurance Act.

"Professor W. Russell (Edinburgh) said at present it was proposed to bring all persons with salaries up to £250 a year into the State Insurance Service. The heads of departments were striving for more power and authority, and to be the autocrats over a servile profession. Except in the case of the necessitous, or of a particular disease, the State had no right to interfere with the relations between man and man. The new proposal had grown out of the Insurance Act, which was regarded, especially

constant change and adaptation during the last quarter of a century. Each change has taken place in response to some new demand, the outcome, as a rule, of discovery or invention. Thus we have seen in succession special departments of medicine dealing with tuberculosis, venereal diseases and infant welfare accorded a State sanction and State aid. Within recent years, too, *the National Health Insurance Act has altered fundamentally the complexion of general practice* and brought the majority of doctors into more or less loose relationship with the governing authority. How long this process of development might have gone on in its rather haphazard way had not the war taken place it is impossible to state. The war raised the doctor and his craft to more obvious importance, and so well, all things considered, did he bear himself in this situation that there came the demand for a new recognition of his services which found its expression in the Ministry of Health."

It is little less than fatuous to ignore these self-evident facts in the evolution of medicine as a healing art. Medical practice has become within a single generation a matter of the utmost concern to the state, held justly responsible for much of the prevailing ill health and physical impairment as disclosed by the medical experience of the war. England in this respect has much more thoroughly realized its future duties than the United States, and whatever view may be held regarding the medical or general administration of national health insurance, there can be no divided opinion as to the profound advance made in the public recognition of the proper place of preventive medicine in the political administration of the modern state.* The Medical Consultative Council appointed

*Of interest is the following article on "The Plight of Petrograd Doctors" under Bolshevism and Soviet rule (*B. M. J.*, July 31, 1920): "The state of affairs among the doctors in Petrograd is reported by the *Tidsskrift for den Norske Laegeforening* of June 15th to be most distressing. During the recent epidemic of typhus the mortality among the doctors in attendance was between 45 and 50 per cent., whereas the mortality for the whole of Petrograd's population was only between 8 and 9 per cent. The doctors have been nationalized, are regarded as the Government's employees, and are disqualified from earning an independent living. Their official monthly wage is, on the average, between 5,000 and 6,000 roubles *plus* a double food ration, which includes half a pound of bread a day; they are entitled also to one public meal a day, consisting of soup and horse flesh. On this dietary the doctors in Petrograd have, during the past two years, carried out most onerous duties, which have been augmented by epidemics of cholera and dysentery in the summer and of small-pox and typhus in the winter. Of the 4,000 doctors resident in Petrograd before the war only about 800 are left; most of the rest have died of starvation, overwork and epidemic diseases. Their work has generally to be done on foot. The trams are so lice-infested that their use entails grave risks of typhus, and the cost of a horse and vehicle is about 2,000 roubles an hour. The few motor cars in existence are not available for doctors.

in Scotland, as a failure. The Act was a political bribe to the manual labour section of the community, and had resulted in breaking in two the medical profession. The question was one not only for the profession, but also for the general community. The Guild stood for freedom of relations between the public and the medical profession; nobody should be forced into the acceptance of such a service, but it should be open to those who wished to use it.

"Dr. E. Duncan (Glasgow) said he had grave suspicions of the intention of the Government in the immediate future, and that great dangers were ahead. During the last 50 years there had been various forms of government, and we had now arrived at what was supposed to be pure democracy. Such periods invariably ended in tyranny, and now a tyranny was established in which heads of departments were doing as they liked independent of the Government and of public opinion. At present these heads were chosen from political superiors, and it did not matter whether they were competent or not. It was time the medical profession insisted on having its rights conserved, and resisted a service which would divorce the practitioner from his patient. The present system of medical practice was much more to the advantage of the public than any described by advocates of a State service.

"Other speakers emphasised the importance of organisation of the profession, and the education of students and of the general public in the question.

"Dr. F. Porter (Edinburgh) said he understood that the sweeping aside of the National Insurance Act was under consideration, and on his proposal a motion was carried that they should urge for the abolition of the Medical Benefit Section of the Act, but retention of the Sick Benefit Section, and doubling of the amounts paid under it."

by the Ministry of Health is therefore most likely in the future to exercise a dominant influence in the practical development of medicine as a healing art, in addition to disease prevention and control. In this respect the British view-point is much further advanced than the corresponding public opinion in the United States.*

The Ministry of Health

The practical difficulty in Great Britain is the inclusion of political duties or functions in the Ministry of Health, of such widely different methods of administration as the poor law and housing reform on the one hand and national health insurance on the other. It seems a wrongful perversion of a public function to burden a Ministry of Health with economic projects involving hundreds of millions of expenditures in behalf of an effort to relieve the intolerable condition of housing congestion in industrial districts. If housing reform has thus far failed to materialize, this is the fault of a political system which holds a Minister responsible for medical and public health functions, though charged at the same time with enormous economic responsibilities. It has properly been pointed out by a correspondent in a letter to the *Lancet*, of February 21, 1920, that medical practice in England is in its present state in a transitional period, and it is only necessary to refer to the epoch-making treatise on "The Future of Medicine," by Sir James Mackenzie, to emphasize the confused state of the public mind on questions of the utmost importance not only to the public and the state, but to the future as well as to the present generation.† The work by Sir James Mackenzie, for the first time emphasizes the view-point of an authority of international reputation that medicine as a healing art at the present time has little practical concern with the conditions or circumstances which predispose to disease or premature death. As said by Sir James Mackenzie in "The Future of Medicine," few or no attempts are made "to train men for the detection of disease when there is hope of a cure," and, "if we do not know the early signs of disease there is little hope of our achieving the aim of medicine—the prevention of disease." For the aim of medicine as a healing art is the cure of the patient and not the prevention of the disease from which he suffers. It is of the utmost importance that it should be clearly recognized that *the prevention of death from disease is by no means the equivalent of the prevention of the conditions or circumstances which give rise to disease.* And it is equally true, as said by Sir James Mackenzie, that "the

*The most convincing illustration of this perhaps somewhat disturbing view-point is the first report of the Welsh Consultative Council of Medical and Allied Services in Wales, issued by the Ministry of Health, under date of May, 1920. Of additional importance is the Lady Priestly Memorial Lecture by Sir George Newman, principal medical officer of the Ministry of Health, on "The Place of Public Opinion in Preventive Medicine and the Need for an Educated Community," P. S. King & Son, Great Smith Street, London, price 4d.

†This danger is best illustrated by a work on "Medical Chaos and Crime," by Norman Barnesby, M.D., New York, 1910, and an earlier work on the "Vagaries of Sanitary Science," by F. L. Dibble, M.D., Philadelphia, Pa., 1893. Much harm is being done to the cause of health-promoting agencies, both governmental and voluntary, by ill-advised utterances easily discredited by the facts of subsequent experience.

bulk of patients in the early stages of disease are never seen by those who are systematically engaged in its investigation." As a first step in the direction of a better medical service there has been established by St. Andrews University, Scotland, an institute for clinical research, of which Sir James Mackenzie is the director. The direction which the future investigations of this institute are likely to take are foreshadowed in Sir James Mackenzie's treatise on "The Future of Medicine," and in an earlier work on "Symptoms and Their Interpretation," and numerous contributions to the scientific study of diseases or affections of the heart. From another point of view the more practical and hopeful methods of modern research are indicated in a treatise on the "Early Diagnosis of Tubercle," by Clive Riviere, which touches upon aspects of the utmost importance to a large element of the population now foredoomed to early death because of the failure of the modern tuberculosis movement to realize the glittering promises held out for more than thirty years.

Agitation for a State Medical Service

None of these movements owe their origin to national health insurance as a system which virtually places a premium on the treatment of trivial complaints to the neglect of the more serious afflictions, which in a large measure still remain subject to the poor law. A new demand has therefore arisen for a recasting of the national health insurance system virtually equivalent to the establishment of a state medical service open to all.* Those who favor such a service limited to the necessitous poor represent largely the English point of view which continues to favor class distinctions, incompatible with the higher conceptions of progress in a true democracy. The literature of this controversy is too extensive to be referred to more than in a general way, but the most important sources of information are the quarterly *National Medical Journal*, issued by the National Medical Union (346 Strand, London) and the *Medical World*, the official organ of the Medico-Political Union. Much information of value is also contained in the *Medical Officer*, a journal for medical men in the government and municipal services; but of special value are the publications of the Medical Guild of Edinburgh, of which Dr. John Playfair is the president and Dr. Frederick Porter the secretary. Of special importance are the papers listed below:

"Should the Medical Profession be a State Service?" by Charles A. Parker, F.R.C.S., printed in *Progress* for October, 1912.

*In discussions of the broadening sphere of the state in its relation to the medical profession, the all-important fact is frequently overlooked that to an increasing extent perfectly legitimate demands are made for an enlargement of the medical staffs of the government. The *Hospital*, under date of August 16, 1919, for illustration, called attention to the demand for doctors on the part of the Ministry of Pensions, utilizing, at the time, the services of something like 3,000 physicians on the various boards, while another thousand were reported to be officially employed outside of the board in the medical supervision of the disabled. At the same time attention was called to the practical difficulties of young doctors securing a sufficiently remunerative practice, and the advantages in this respect of the government medical service, with fixed salaries, which, "except in the case of gross professional mistakes, reduce the chances of failure to a minimum." It is precisely the chance of failure which lies at the root of the successful careers which rank far above the average in professional skill.

"A Medical Service for the Genuinely Necessitous Classes of the Community and for Them Only," by Vivian T. Greenyer, F.R.C.S., vice president and chairman of the Council of the National Medical Union, 1916.

"A State Medical Service," by Charles A. Parker, *Fortnightly Review*, 1913.

"A State Medical Service," D. T. Jenkins, in *The Journal* of the Iron and Steel Trades Confederation, February, 1920.

"A Public Medical Service," by David McKail, M.D., and William Jones, Glasgow, 1919.

Address on "The Relationship Between Medicine and Public Health," by the Right Honorable John Burns, M.P., London, 1914.

"The Medical Man and the National Health Insurance Act," a lecture by Sir John Collie, Cambridge, 1916.

"The Ministry of Health and a State Medical Service," by Dr. Playfair, Dr. Porter, Dr. Russell, and others. A discussion of special importance, each writer contributing the view-point of the Medical Guild of Edinburgh, London, 1917.

Of historical value are the following:

"The Medical Attendance of Londoners," by the late Sir Henry Burdette, London, 1903.

"Out-Door Medical Treatment of the Poor," issued by the Charity Organization Society, London, 1911.

"A National Medical Service," by Dr. Milson Russen Rhodes, Manchester, 1912.

A discussion of "A National Medical Service," by F. Lawson Dodd, issued by the Fabian Society, London, 1911.

"The Effect of the Insurance Act on Accident and Compensation Claims," by J. Scott Duckers, London, 1912.

"The State Medical Service Scheme," by J. E. Esslemont, a paper read before the Bournemouth Division of the British Medical Association, October 2, 1912.

"The Panel Doctor and the Insurance Act," by Charles A. Parker, reprinted from the *Medical World*.

"A Few Reasons for Advocating a State Medical Service," issued by the State Medical Service Association, London, n.d.

"First Steps Towards a State Medical Service," by Benjamin Moore, London, 1913, a paper of considerable importance.

"National Medical Treatment," by Wm. J. Howarth, M.D., and B. A. Richmond; reprinted from the *British Medical Journal* of March 8, 1919.

"A Vision of a State Medical Service," by Col. G. T. Maurice; reprinted from the *Hospital,* November, 1918.

"Public Health vs. the State," by Bertram G. M. Baskett, M.D., Rayleigh. An address delivered before the South Essex Division B.M.A., October, 1919.

"Public Health," Parts I and II. Reconstruction pamphlet No. 23. Ministry of Reconstruction, 1919.

Of the first importance, however, are the extended observations on poor law medical service in the majority and minority reports of the Royal Commission on the Poor Law and Relief of Distress; London, 1909; and the just issued report on the hospital and nursing services in Scotland (National Health Insurance Commission, Scotland), which contains an extraordinary amount of most useful information.*

A Divided Medical Profession

I have thought it advisable to include the foregoing bibliographic list of references to the general literature of the controversy concerning a state medical service, which, though far from complete, is probably sufficient for the purpose of illustrating the wide degree of cleavage between the medical profession and the correlated public health activities which has resulted from the British national health insurance act. It, however, requires no extended knowledge of the literature of the subject to disclose the truly astonishing amount of thoughtful consideration of a matter which heretofore has practically been left to men without much practical experience or direction in public affairs.

*In America this demand is manifest in the increasing insistence upon the practical value of group medicine. A word of warning in this respect has recently been given utterance in an editorial in *Minnesota Medicine,* March, 1920; but for an excellent presentation of views in favor of such a burdening of medical practice see an article on "Social Service and the Clinic," by Dr. Alfred C. Reed, of San Francisco, in the Boston *Medical and Surgical Journal,* May 6, 1920. And much along the same line of development are the modern medical service departments of large business corporations, perhaps best illustrated by an outline of organization and functions prepared by Robert S. Quimby, of the Hood Rubber Co., Watertown, Mass., for *American Industry,* 1920. Most of these efforts rest upon the extraordinary experience of the Mayo Clinic of Rochester, Minn., where group diagnosis has probably reached the point of highest perfection.

Aside from the foregoing, there are two further publications of really extraordinary value, the first being an address on "The Nation's Welfare,—The Future of the Medical Profession," by Sir (now Lord) Bertrand Dawson, including a plan for a model health center, London, 1918, and "An Outline of the Practice of Preventive Medicine," being a memorandum addressed to the Minister of Health by Sir George Newman, K.C.B., London, 1919. (Invaluable also is the *National Medical Journal,* 346, Strand, London.)

The Consultative Council

The appointment of Lord Dawson of Penn as chairman of the Consultative Council may be accepted as evidence of the good faith of the Ministry and proof that there is a firm intention on the part of the government to bring order out of chaos and to evolve a new system of medical practice productive of more satisfactory and far-reaching results in all its aspects. As a first step in this direction mention may be made of the new regulations issued in March by the Board of Education in respect to the medical records of school children in the secondary and continuation schools, which, as observed in the London *Times* of March 25, 1920, "lays the foundation of a real census of national health." It is further pointed out that under the new system it is provided that "when a child leaves a public and elementary school and enters a school not under the same authority, particulars of his medical record shall be forwarded with him." This recommendation is in precise conformity with a suggestion made in my address on "A Plan for a More Effective Federal and State Health Administration," but with a much less chance of being realized in actual practice.* It, however, is true of England today, as said in the *Times*, that "we are well within sight of the time when every individual on the threshhold of a career will possess a complete health record going back to birth or going before it," and "it will thus be possible for the first time to realize the ideal we have constantly set before ourselves—the choice by industry of men and women fitted in a physical sense for its requirements."

Proposed Reforms in Public Health Administration

America missed the opportunity to inaugurate such a service in advance of the suggestions made by the principal medical officer of the Ministry of Health, and we are far from having realized more than the preliminary steps of a school medical service really worthy of the name. The Medical Consultative Council, through Lord Dawson of Penn, has recently presented a report to the Ministry of Health in which much of the foregoing consideration is subjected to critical analysis, amplified with practical suggestions which unquestionably will prove of far-reaching value in the future development of medicine and public health.† The report has been reprinted in the *British Medical Journal*, May 29, 1920, and no document of recent times deserves wider attention. The Council includes, among others, Sir William S. Glyn-Jones, secretary to the Pharmaceutical Society, Mr. E. W. Morris, House Governor of the London

*The urgency of trustworthy and comparable international data is illustrated by a wholly misleading discussion of "English and American Children," in the issue of the *Hospital* for January 24, 1920. This article includes an estimate that from fifteen to twenty-five per cent. of the school children of the United States are undernourished, a statement based entirely upon pure conjecture or fragmentary data not permissible for general conclusions. Such statements can only increase the existing amount of confusion and bring both statistics and public health into public contempt.

†Interim report on the "Future Provision of Medical and Allied Services," of the Consultative Council on Medical and Allied Services, Ministry of Health (Cmd. 693); London, 1920. Price 1s. net. P. S. King & Son, 2 and 4 Great Smith Street, Westminster, S. W. 1. This report includes illustrations of the floor plans of buildings proposed for primary health centers.

Hospital, Dr. John Robertson, the Medical Officer of Health of Birmingham, and others thoroughly representative of the medical profession of Great Britain. It would be impossible with the required brevity to present the suggestions made in this report, even in outline, but the following is a summary of the recommendations as given in the *British Medical Journal:*

"A. *Domiciliary*—including both curative and preventive work.

"Personnel.—Doctors; pharmacists; nurses; midwives; health visitors and other officers of the health authority.

"B. *Primary Health Centres*—including medical, surgical, and maternity beds; out-patient clinics; dental clinics; accommodation for equipment needed for treatment and investigation; accommodation for the work of communal services; ambulance service.

"Personnel.—General practitioners; visiting consultants and specialists; officers engaged in communal services; visiting dental surgeons; workers in ancillary services.

"C. *Secondary Health Centres*—including facilities for curative services in cases requiring highly specialized diagnosis or treatment; accommodation for the work of communal services; dental clinics; accommodation for workers in ancillary services; ambulance service.

"Personnel.—Consultants and specialists; officers engaged in communal services; dental surgeons; workers in ancillary services.

"D. *Supplementary Services*—including provision for facilities for specialized treatment of such conditions as tuberculosis, mental disease, etc.

"Personnel.—Specialists in the appropriate forms of treatment; workers in ancillary services.

"E. *Teaching Hospitals with Medical Schools*—including facilities for treatment of cases of unusual difficulty; facilities for research; facilities for post-graduate study (including training for communal services).

"Personnel.—Consultant, teaching and research staff; workers in ancillary services.

"F and G. *Research: Clinical Records*—it is recommended that provision should be included in any scheme for (F) the encouragement of research, and (G) the operation of a system of standardized clinical records.

"H, I, and K. *Administration*—recommendations as to the principles of administration are submitted: (H), the establishment of a single health authority to supervise the local administration of all medical and allied services, whether curative or preventive; (I), representation of the medical profession on each such authority; (K), establishment of local medical advisory councils."

In connection with this report it is urgently suggested that there should be read the presidential address of Lord Dawson of Penn, on "Medicine and the State," reprinted in the same issue of the *British Medical Journal* (May 29, 1920). Lord Dawson of Penn does not favor a state medical service in the generally accepted sense of the term, but it is true, as said in his address on "The Nation's Welfare, or the Future of the Medical Profession," that "never within memory has the profession been faced with issues so momentous as now—issues which involve the future welfare and prosperity of the nation and our own position in the ranks of its trusted leaders. We are at the parting of the ways. Do let it be the way of a large and comprehensive outlook leading to strong and effective action."

Urgency of Radical Changes

It is in this sense that the more restricted problem of national health insurance in its relation to the medical profession should be considered. The evidence available proves conclusively an existing amount of discontent with the results achieved that make radical changes an imperative necessity. Nothing is gained by the continuation of a delusion harmful alike to the profession, the patient and the state.* National health insurance is *not* national; does *not* promote health; and is *not* insurance. It is of the utmost importance that terms should be used in their proper sense and that there should be an end to false pretensions made solely out of considerations of political expediency. The propaganda for compulsory health insurance in the United States rests upon the same false pretenses as did the political agitation for national health insurance in Great Britain.† The health of the people and the needs of the sick are properly entitled to the utmost solicitude on the part of the state. They are not fit subjects for political controversy or suitable objects for personal gain. As I have tried to show in my "Facts and Fallacies of Compulsory Health Insurance," and in my "More Facts and Fallacies," the propaganda rests essentially upon insincere pretensions, upon false evidence and, last, not least, upon an utter disregard of the true interests of the people, the medical profession and the state.

*It is easy enough to say that "the British citizen can usually be trusted to take good care that his political and other rights are not filched from him" (*Pharmaceutical Journal*, April 17, 1920), but the British citizen is practically helpless against a campaign which deliberately confuses public opinion and withholds the truth in a form readily within the public understanding. Regardless of the complacent attitude of the *Pharmaceutical Journal*, it is only necessary to quote from its issue of April 17, 1920, the significant statement that, "At the Merioneth Health Insurance Committee meeting on April 8, at Dolgelly, it was reported that there was a paucity of chemists on the county panel. At Barmouth it was necessary to use compulsory powers to get drugs for insured persons, as local chemists had withdrawn from the panel." Equally disturbing reports have come from Scotland, and there is no question of widespread dissatisfaction on the part of the pharmaceutical profession with the workings of national insurance affecting pharmaceutical interests. With a dissatisfied medical profession and a dissatisfied pharmaceutical profession, it is not likely that the patient will receive the best treatment, to which of right he is entitled. In my judgment, based partly upon the similar German experience, it is a foregone conclusion that there will arise a demand for *a public pharmaceutical service* just as there has already arisen a demand for a public medical service. The interests of both professions are not advanced by a wilful disregard of the obvious facts of everyday experience.

†The general facts of the British national health insurance system have been presented in an address on "Methods and Results of National Health Insurance in Great Britain" (preliminary report) and this has been amplified by a subsequent paper on the "Poor Law Aspects of National Health Insurance," Newark, 1920.

Value of Sanatorium Treatment

The best illustration of the confused state of public opinion is the recent transfer of sanatorium benefit to the local authorities. This change was imperatively called for by the largely negative results of sanatorium treatment under national health insurance. A consideration of this question lies outside of the scope of the present discussion, but a few illustrations will suffice to emphasize the misleading nature of the early proposals made by Mr. Lloyd George and others offering to the insured public the hope of "first-class hotels" for the treatment of tuberculosis. In an article contributed to the February, 1919, issue of *Reveille,* by an anonymous author, but assumed to have been the late Sir Robert Morant, the whole question is reviewed with admirable clearness, although the failure of sanatorium treatment is passed over with the statement that "the controversy is due rather to a misconception of the true function of the sanatorium," it being said that "this is a necessary phase of treatment, but it is not the whole of it." As a matter of fact, however, the assumption itself is erroneous. The sanatorium treatment at best is but one of alleviation or cure but not one of effective control. As long as existing conditions giving rise to tuberculosis are allowed to prevail, so long the burden of treatment and cure will fall with crushing weight upon the community concerned. Sanatorium treatment is unquestionably an indispensable element of the tuberculosis problem, but it does not bear directly and effectively upon the larger question of disease prevention and control. In this connection, I may quote from the London *Times* of June 18, 1920, a statement to the effect that out of 1,086 sanatorium cases treated only fourteen had been announced cured! The article reads, in part, as follows:

"Under the title of 'A Survey of Sanatorium Benefit,' Dr. W. H. Dickinson, Medical Advisor of the Insurance Committee of Newscastle-on-Tyne, affords a depressing picture of the prospects of the industrial consumptive. He gives figures and data from which it appears that out of 1,086 cases only fourteen in which tubercle bacilli were found in the sputum had secured 'arrest' of disease and were still alive and well when the report was completed. Even this is not the worst of the matter, for in respect of six of these there was some doubt as to the accuracy of the original observation, leaving only eight certain cases."

In continuation it is said:

"This gloomy outlook is further illustrated by the histories of 1,162 cases, of which number 733 died while receiving sanatorium benefit, a further sixty-four died after discontinuing the treatment, making a total of 797 known deaths. Treatment was stopped on account of 'arrest' of disease in only 108 instances. Of these latter persons eighty-one are now

working or fit for work, four are known to have died, nine are still alive but have relapsed, and fourteen cannot be traced."

The conclusion is therefore advanced that:

"It is no exaggeration to say that the outlook for a patient of the industrial classes in whose sputum tubercle bacilli have been demonstrated on at least two occasions is well-nigh hopeless under conditions similar to those which have prevailed in the past."

And finally the article continues:

"Although much suffering has been relieved and many lives prolonged, the results achieved, as measured by the number of patients cured or restored to full working capacity, are very disappointing, considering the amount of money and energy expended, and it behooves us to find out where we have failed and why."

In contrast to the foregoing is the following statement of results obtained at the Loomis Sanatorium, Liberty, New York: Out of 1,290 cases successfully traced to October 31, 1918, 1,141, or 88.5 per cent., were reported alive. Of this number 82.6 per cent. were in a satisfactory condition of health, 15.6 per cent. in an unsatisfactory condition, while for 1.9 per cent. the physical condition could not be ascertained. As far as it is possible to judge, American sanatorium experience has yielded better results with a lower death rate and a larger rate of effectiveness for work than either the English or German experience.* This is to be attributed chiefly to the longer average duration of treatment, which, as elsewhere pointed out, in English sanatoria as well as in German institutions is, for economic reasons, entirely too short.†

The Removal of Sanatorium Benefit from National Health Insurance

It is therefore a most hopeful indication of a return to sanity and common sense that sanatorium treatment should have been removed from the national health insurance acts and been placed where it belongs, under the control of the local authorities. Unfortunately the conflict of local authority and departmental jealousy have had much to do with the slow progress which has been made in the past. It is difficult to understand why such admirable results should be achieved in one direction while practically nothing is being done in others. The enormous present activity in behalf of rehousing schemes is but a late recognition of one of the most important underlying causative factors. Even more important as

*At the municipal tuberculosis sanatorium of the city of Chicago the average duration of treatment for the year 1918 was 153 days, and for 1919, 137 days. No sanatorium under compulsory health insurance in either Great Britain or Germany grants to the same class of patients an average duration corresponding to the length of treatment common to American municipal institutions.

†According to an original investigation of the sanatoria experience of representative American institutions for the period 1909-1913, the proportion of apparently cured cases was for incipient cases, 43.1 per cent., for moderately advanced cases, 10 per cent., and for far advanced cases, 0.6 per cent. This investigation was based on 6,767 observed cases.

regards the wage-earner are the health conditions in industry. The mortality in dusty trades, for illustration, has nowhere been more clearly recognized than in England. From the classic work by Dr. Arlidge in his investigations into the mortality of potters, to the equally far-reaching researches of Dr. Shurfeld, Dr. Barwise and Sir Thomas Oliver, and the epoch-making investigations of Dr. L. Edgar Collis on pneumonoconiosis, a body of evidence has been brought together fully sufficient as a basis for radical and far-reaching preventive measures. As bearing upon this question, I may quote from a recent article by a correspondent to the London *Times* (Trade Supplement, May 8, 1920), with reference to "Unsafe City Offices," that "the employer who engages the services of men and women to work in his office has as much to gain by considerations of health and welfare as the manufacturer," yet "the present-day office, in London, at any rate, is constructed on principles which even backward manufacturers would condemn. It is in the first place very frequently ill-lit. One goes into the headquarters of firms the names of which are known all over the world and finds these places too often dingy and dreary to a degree. The windows appear to afford a minimum of light and quite commonly are not cleaned except at rare intervals." This is spoken of as a mistaken attitude on the part of business men. It is said, "This attitude, which is widely prevalent, betrays a complete lack of understanding of the meaning of industrial hygiene." In other words, until the consciousness of the importance of far-reaching methods of disease prevention is much more common than is at present the case, the outlook for a substantial reduction in the tuberculosis death rate is practically hopeless. Under such conditions sanatorium treatment could at best but prove a means of amelioration and relief, typical rather of a liberal interpretation of the poor law than of a clear recognition of the principles and practice of preventive medicine.

Recent British Experience

To the foregoing I add a further illustration, based upon recent observations in the annual report of Dr. Robert A. Lyster, of the Hampshire County Council for 1918. According to this report the average duration of sanatorium treatment was only 71 days for insured patients against 125 days for uninsured patients. The duration of treatment decreased during recent years for insured persons from 93 days in 1914 to 71 days in 1918; but the average duration increased for uninsured persons from 89 days in 1914 to 125 days in 1918. Dr. Lyster, who is recognized as an authority on the practical administration of sanatorium benefit, observes, however, in this connection, that "with regard to the average stay and the apparent extraordinary contrast in this respect between the insured and the uninsured, it may be pointed out that the average stay of the latter is greatly increased by the number of children dealt with. These are, of course, uninsured, and many of these remain in the hos-

pital for quite long periods. As to adult cases, the general rough and ready rule is for the patient to remain in the institution in the first instance for two months, and the question of stay to be reconsidered after that period." It is this question which takes up so much of the attention of insurance committees, much time being wasted in endless deliberations, chiefly with reference to the available means of the insured to pay for his own treatment. Dr. Lyster's explanation does not, however, touch upon the low average duration of treatment for insured cases, which, by every modern standard, is less than one-half of what it should be; nor does he touch upon the even more important question as to why the average duration during the last five years should have decreased when every authority upon the subject is urgently insisting upon a material prolongation of institutional care. At the municipal sanatorium of the city of Chicago, the average duration of treatment is approximately 180 days, or more than twice the average length of stay granted to insured patients by the Hampshire County Council, which in this respect represents fairly typical conditions of Great Britain.

Sanatorium Treatment Not a Failure

Nothing contained in these observations should be construed as a reflection upon the wholly admirable efforts which have been made by the medical and public health professions of Great Britain to solve the problem of adequate sanatorium treatment. The institutions which it has been my personal privilege to visit have left only the best possible impressions. The exceptionally successful work of Dr. Varrier Jones at the Papworth Colony, near Cambridge, for the after-care of tuberculosis cases, need only be referred to as an illustration. The fault lies with a system under which a vast amount of time is wasted in useless discussions and the exacting demands for the needs of a needless bureaucracy. It was a serious error to include so-called sanatorium treatment within the provisions of the national health insurance acts. The provision was, from the outset, a serious deception of the public in that the government did not have the required institutions available for the purpose, nor would the government have been able to establish a sufficient number of new institutions within a reasonable period of time even if the war had not otherwise interfered. It was also an unjust discrimination in the case of the insured, who had paid for the treatment, by the enforced equality with the uninsured patients who had not. But the growing reliance upon domiciliary treatment is in itself evidence of a failure to carry into effect the promises held out at the time the act went into operation and which, if complied with, would have imposed upon the British public truly enormous financial burdens.

Sanatarium treatment is at best difficult and expensive. The difficulty lies as much if not more with the patient, often unwilling and unreasonable,

as with the medical staff, more or less unable to meet the exacting requirements of a critical situation. But Great Britain has every reason to point with pride to a large number of thoroughly well managed institutions, and to the results which are being secured and which grow better with the increase in experience. Such institutions as those at Aberdeen and Liverpool may be referred to as models for any country to follow. The fault which is found concerns the misconception that national health insurance was a measure of real and exceptional benefit in the furtherance of the tuberculosis movement. In other words, it is sanatorium *benefit* that is here referred to as a failure, and not sanatorium *treatment*, given at the proper time, for a period of sufficient length and under conditions in conformity to modern medical, dietary and labor requirements. It is an entirely safe assumption that if the same expenditure of money had been diverted from the outset into proper public channels of treatment and relief much further and more substantial progress would have been made. I quote in this connection from the report of the insurance committee for the city of Newcastle-upon-Tyne for the period 1912-1919, reading in part that, "While Sanatorium Benefit is only concerned with the provision of treatment, it was very disconcerting to find that instead of the mortality from pulmonary tuberculosis, which was the special object of attack of the combined scheme, decreasing, the death rate actually advanced year by year, until in 1916 it claimed more victims than in any previous year since 1884." I can not accept, however, without further evidence the statement that this increase "is to be attributed entirely to the war," nor that the sanatorium benefit provisions of the act are entitled to credit for the more satisfactory results of the last few years; for the main objective of the act is the prevention of sickness and not its cure, and, as well said in the report referred to, "Seven and one-half years' experience of Sanatorium Benefit has revealed to us our limitations, and has demonstrated beyond question that too much attention has been paid to attempts to cure and far too little to those conditions which precipitate attacks of actual clinical tuberculosis and cause relapse."

Domiciliary Treatment

The tendency in England has been towards an increasing amount of so-called "domiciliary," or home, treatment. For illustration, the number of patients treated in behalf of the Insurance Committee of London in 1913 was 3,377 patients in residential institutions against 5,360 in 1919, but the number of patients treated at home increased during the same period from 3,222 to 8,364. With reference to domiciliary treatment it is officially stated that "an investigation has been in progress during the whole of the year into cases recommended at any time since the commencement of the Acts for domiciliary or dispensary forms of treatment. Domiciliary treatment consists of treatment by the insurance doctor with or without extra nourishment and includes the furnishing by the doc-

tors or the tuberculosis officer of a progress report once in each three months and the examination of the patient by a tuberculosis officer at least once in each year." According to a special return of 4,060 cases treated during 1918 and reported upon at the time of discharge, the number capable of work was 342, or 8.4 per cent.; the number capable of light work was 1,560, or 38.1 per cent.; the number unfit for work on discharge was 2,016, or 50 per cent.; while the number of deaths in the institution was 142, or 3.5 per cent. of the total.

After-Care

These results represent probably the best that is obtainable at the present time without supplementary treatment in after-care colonies. The brevity of the treatment in London institutions during the year 1918 is best emphasized by the statement that of the 4,060 cases discharged, 555, or 13.6 per cent., had been less than one month under treatment; 1,052, or 25.9 per cent., from one to two months; 980, or 24.2 per cent., from two to three months; and 776, or 19.2 per cent., from three to four months. In other words, of the total number discharged, only 210, or 5.2 per cent., had been more than six months under treatment! How far this treatment squares with the promise of Mr. Lloyd George that the tuberculous under national health insurance would receive treatment equivalent to "first-class hotel accommodations" is a matter of conjecture. But as regards those who do not even receive institutional treatment, but have to be satisfied with domiciliary treatment, it is officially of record on the part of the London Insurance Committee that "domiciliary treatment is entirely unsatisfactory in many respects." No part of the tuberculosis scheme, however, is of such importance. Moreover, with a tendency to exclude the more advanced cases from sanatoriums, the necessity for good domiciliary treatment increases. Although domiciliary treatment could only with great difficulty be made more effective as a means of curing tuberculosis, more could be done for the comfort of patients and for the protection of their families, and for the prevention of the social deterioration of patients and their dependents.

Modern Problem of Disease Prevention

All of this, however, does not solve the problem of supreme importance—the successful prevention of the disease. It can be readily understood, however, that the present trend should be more and more towards a public medical service. For all the evidence available proves conclusively that the present state machinery for such a service is totally inadequate, ill-trained and possibly hopelessly out of touch with the needs of a situation not far from alarming. Neither in Great Britain nor in the United States are government establishments or public offices a model for private establishments to follow. The safety-first movement in industry was initiated by private enterprise, and it was only

in response to the most insistent demands that the United States Government during the war finally provided adequate safety precautions for the protection of the workers in government industrial establishments. Public offices are notoriously unhealthful, as is best illustrated by courthouses and prisons, frequently condemned as lamentably below standards long since accepted as customary in private life. As a concrete illustration I include here the following, from the London *Times*, on "Unhealthy Government Offices" (April 24, 1920), reading in part as follows:

"The Association of Civil Service Assistant Clerks and the Association of Women Clerks and Secretaries have written to the Minister of Health, the Minister of Education, and the First Commissioner of Works complaining of the basement courts in which some of their members are working in the block of buildings in Parliament Street, occupied by the Ministry of Health and the Board of Education.

"Those courts, it is understood, are some twenty feet or thirty feet below the street level, and are ventilated only from dark and unsavory corridors. There is no direct access to fresh air, and to make matters worse, it is asserted that sewage pipes run through the corridors which afford the only means of ventilation available."

Similar protests have been lodged against the Minister of Health in connection with the building of certain groups of new and alleged model houses, on the ground that essential provisions of the sanitary code were violated in their construction.

In this as in many other matters it is quite clear that the government has undertaken a vastly greater task than it is able to fulfil. There can be nothing more dangerous than to raise the expectation of the public in matters of life and health only to bitterly disappoint it in the end.

The Proper Sphere and Function of the State

In fairness to the government authorities it is but proper to point out that the difficulties to be overcome are indeed most formidable. As said elsewhere, I, for one, cannot but feel a sense of profound respect for the administrative ability of the health insurance branches of the British civil service, with which I am reasonably familiar. It is not so much that fault is found with methods of administration as that it is of the utmost importance that a thoroughly false administrative principle should be realized, in that the state undertakes functions which properly belong to private initiative and private enterprise. The sphere of the state is naturally subject to laws of growth and tends normally to develop in response to a broader outlook and a proper demand for efficiency and the intelligent coordination of germane functions, but the mere increase in power on the part of the state in response to socialistic propaganda without a corresponding ability to manage and direct foreshadows the possibility of ultimate disaster, which may fall not far short of a revolution. I believe that the safest democratic doctrine of the past, as of the present age, is that the government which governs best is the government which governs least.

APPENDIX A

TERMS OF SERVICE FOR PRACTITIONERS

Admission to and Withdrawal from Medical List: Method of Altering Terms of Service

1. Every practitioner, other than a practitioner disqualified from undertaking service by reason of his name having been removed, after an inquiry, from any medical list in Great Britain, who gives notice to the Committee that he accepts service upon the terms for the time being in operation in the Committee's area will have his name included in the Committee's medical list. Such notice must be given in the form set out in Part III. of the Schedule, with such modifications, if any, as the circumstances may require.

2. The Committee may, after consultation with the Local Medical Committee and Panel Committee, and subject to the approval of the Minister, alter the terms of service as from such date as the Minister may approve by giving notice of the proposed alterations to each practitioner:

Provided that, except in the case of an alteration which results from the coming into operation of any new Regulations, Order, Order in Council, or Act of Parliament, the alteration shall not come into operation within a period of three months from the date of the issue of the notice.

3. A practitioner is entitled at any time to give notice to the Committee that he desires to withdraw his name from the medical list, and his name shall be removed therefrom at the expiration of three months from the date of such notice or of such shorter period as the Committee may agree:

Provided that:—

(i) if such notice is given by the practitioner within one month after the issue to him by the Committee of a notice informing him of a proposed alteration in the terms of service (including any amendment of the Allocation Scheme), two months shall be substituted for three months as the maximum period for which he may be required to continue to undertake insurance practice; and

(ii) if representation have been made to the Ministry that the continuance of a practitioner on the medical list would be prejudicial to the efficiency of the medical service, he is not entitled to withdraw his name from the medical list, except with the consent of the Minister and subject to such conditions, if any, as the Minister may impose, during the period while an Inquiry under Part VI. of these Regulations, or action by the Minister as a result of such Inquiry, is pending.

Arrangements for Practice on Retirement or Death

4.—(1) During the period from the date on which these terms of service come into operation to the end of the year 1922, a practitioner whose name was included in the Committee's medical list on the 31st day of December, 1919, and who subsequently withdraws from the list, or the representative of a deceased practitioner whose name was so included, may not later than the date of the withdrawal from the list or within two months from the death of the practitioner, as the case may be, require the Committee to give notice to each insured person included in his list that arrangements have been made for the insured person's transfer to the list of another practitioner and that unless the insured person notifies the Committee within 14 days after the issue of such notice that he objects to such transfer he will be deemed to have consented thereto. The preparation and dispatch of such notices by the Committee will be at the expense of the practitioner or of his representative, as the case may be,

and the Committee may recover the cost thereof by deduction from any remuneration payable to him or to his representative or otherwise.

(2) If a practitioner who withdraws from the medical list, or the representative of a deceased practitioner, is not entitled or has not elected to require the Committee to give notice under the preceding paragraph, he may, not later than the date of the withdrawal from the list, or, in the case of the death of the practitioner, within the period for which the Committee may permit the practice to be carried on by a deputy under paragraph (4) of this Clause, require the Committee to state in the notice to be sent to the insured persons on the list of the practitioner the name and address of some other practitioner who is practising or intends to practise in the district and is willing to accept such persons for treatment.

(3) A request made to the Committee under either of the foregoing paragraphs shall be made in writing and signed both by the retiring practitioner or the representative of the deceased practitioner, as the case may be, and by the practitioner who desires to undertake the practice, and the latter shall be deemed to have undertaken to accept any insured person in the list of the retiring or deceased practitioner who does not notify objection or who applies for acceptance, as the case may be.

(4) For the purpose of securing the treatment of insured persons on the list of a deceased practitioner until arrangements are made for their selecting another practitioner, any person may within ten days of the death of the practitioner make application to the Committee on behalf of the estate of the deceased practitioner, and if the Committee are satisfied that he is acting in the interests of the estate, they may authorise him to nominate one or more practitioners, whether being insurance practitioners or not, to undertake the treatment of such of those persons as do not apply to be transferred to the list of another practitioner, and the person or persons so appointed shall be entitled to undertake the treatment as if he were the deputy of the deceased practitioner for such period as the Committee think fit; but such period shall not, except in special circumstances, exceed two months. During such period the name of any insured person who does not apply to be transferred to the list of another practitioner shall not be removed from the list of the deceased practitioner.

Persons for Whose Treatment the Practitioner is Responsible

5.—(1) The persons for whose treatment a practitioner is responsible (hereinafter called his "patients") are—

(a) All persons who have been accepted by him for inclusion in his list and who have not been notified to him by the Committee as having ceased to be on his list.

(b) All persons who have been assigned to him in accordance with the Allocation Scheme and who have not been notified to him by the Committee as having ceased to be on his list.

(c) All persons for whom he may under the terms of the said scheme be required to provide treatment pending their acceptance by or assignment to a practitioner, or to provide treatment in case of accident or other sudden emergency.

(2) A practitioner who declines to accept an applicant for inclusion in his list is required, in addition to providing any treatment immediately needed, to take such steps as may be specified in the said scheme to enable the applicant to be accepted by or assigned to another practitioner.

(3) A practitioner is required to signify his acceptance of an applicant by signing the latter's medical card in the appropriate space and to send the card to the Committee within such period as may be specified in the Allocation Scheme.

Right of Practitioner to Have Patient Removed from His List

6.—(1) A practitioner may have the name of any insured person on his list removed therefrom at the end of June or December in any year by giving notice to

the Committee before the 1st day of June or December as the case may be; but this right is subject to such restrictions as may be imposed thereon by the Allocation Scheme.

(2) If any question is raised by a practitioner as to the conduct of an insured person while receiving treatment and is investigated by the Medical Service Sub-Committee under Part V. of the Regulations, the Committee have power, if the practitioner so request, to arrange for the insured person's transfer to the list of another practitioner.

Evidence of Person's Title to Obtain Treatment

7.—(1) A practitioner is entitled to require a person who applies for treatment as an insured person to produce his medical card. The production of the medical card is to be regarded as conclusive evidence of the applicant's right to treatment, unless *(a)* the practitioner has been notified by the Committee that the card is no longer valid, or *(b)* the card indicates that the applicant is on the list of another practitioner or of an approved institution and the applicant is within the district in which such practitioner or institution has undertaken to treat him.

(2) If a person applies for treatment as an insured person, the practitioner is required to give any necessary treatment (including the supply of any drugs or appliances which he would be required himself to supply to a person presenting a medical card), notwithstanding that the applicant fails, on request, to produce his medical card or that the practitioner has been notified by the Committee that the card produced by the applicant is no longer valid, but the practitioner may charge the applicant a reasonable fee for any treatment rendered, including any drugs or appliances supplied, provided that he gives the applicant a receipt therefor on a form to be provided by the Committee for the purpose. The practitioner must not order any drug or appliance on one of the forms provided by the Committee so as to enable the holder to obtain the drug or appliance free of cost.

(3) If the applicant within 14 days thereafter applies to the Committee for a refund and the Committee are satisfied that he was eligible to receive treatment from the practitioner, the Committee may recover the fee from the practitioner by deduction from his remuneration or otherwise, and, subject to any deduction which may be made by way of inflicting a penalty on the applicant under the Committee's rules, shall repay to the applicant the amount of the fee. If the practitioner has supplied any drug or appliance for which, in the case of a person presenting a medical card, he would have been entitled to payment from the Committee, the Committee will credit him with the amount to which he would have been so entitled.

(4) If the practitioner desires to accept the applicant for inclusion in his list, he will indicate his provisional acceptance on the form referred to above and upon the Committee being satisfied as to the applicant's right to treatment, his name will be placed upon the practitioner's list as from the date when treatment was first given.

Range of Practitioner's Duties

8.—(1) The treatment which a practitioner is required to give to his patients comprises such treatment as is of a kind which can consistently with the best interests of the patient be properly undertaken by a general practitioner of ordinary professional competence and skill; but it does not include treatment in respect of a confinement, that is to say, attendance in labour resulting in the issue of a living child, or attendance in labour after 28 weeks of pregnancy resulting in the issue of a child whether alive or dead, or attendance within 10 days after labour in respect of any condition resulting therefrom.

(2) If the condition of the patient is such as to require services beyond the competence of an ordinary practitioner, the practitioner shall advise the patient as to the steps which should be taken in order to obtain such treatment as his condition may require, and shall, where provision is made for such services in or for the area

by any Public Authority, of which notice has been given by the Committee to the practitioner, take such other steps as may be reasonably necessary in order that the patient may derive full advantage from the provision of such services.

(3) A practitioner is required to attend and treat at the places, on the days, and at the hours to be arranged to the satisfaction of the Committee, any patient who attends there for that purpose, but he may, with the consent of the Committee, which shall not be unreasonably withheld, alter the places, days, or hours of his attendance, or any of them, and shall in that event take such steps as the Committee consider necessary to bring the alteration to the notice of his patients.

(4) A practitioner is required to provide proper and sufficient surgery and waiting-room accommodation for his patients, having regard to the circumstances of his practice.

(5) A practitioner is required to visit and treat a patient whose condition so requires at any place where the patient may at the time be within the district in which the practitioner has under these terms of service undertaken to visit patients.

(6) A practitioner is required to issue medical certificates to his patients free of charge in accordance with the terms of the Medical Certification Rules set out in Part IV. of this Schedule.

(7) A practitioner is responsible for providing the services of another practitioner for administering an anæsthetic, where necessary, in connection with any operation which the practitioner may undertake under these terms of service.

(8) A practitioner is required to supply to a patient where requisite drugs and appliances, which are necessarily or ordinarily administered by a practitioner in person, or are needed for immediate administration or application or needed for use before a supply can conveniently be obtained otherwise under the Regulations.

(9) In the case of any patient to whom the Committee have required the practitioner to supply all requisite drugs and prescribed appliances the practitioner is required to supply such drugs and appliances.

(10) A practitioner is required to order, on a form provided by the Committee for the purpose, such drugs and prescribed appliances (other than those which he is required himself to supply under either of the two preceding paragraphs) as are requisite for the treatment of any patient. The order shall be signed by the practitioner with his own hand and shall not be written in such manner as to necessitate reference on the part of the person supplying the drugs or appliances to a previous order.

(11) A practitioner is required to keep records of the diseases of his patients and of his treatment of them in such form as the Minister may from time to time determine.

(12) A practitioner is required to furnish reports relating to such of his patients as are recommended for domiciliary treatment of tuberculosis and of such other diseases as may from time to time be prescribed at the time and in the form for the time being prescribed by any Order made for that purpose by the Minister.

(13) A practitioner is required—

(a) to furnish in writing to the Medical Officer any information which the latter may require with regard to the case of any patient to whom the practitioner has issued or declined to issue a medical certificate of incapacity for work;

(b) to meet the Medical Officer, when the latter so requires, for the purpose of examining, in consultation, any patient in respect of whom the practitioner has sought the advice of the Medical Officer;

(c) to afford to the Medical Officer, or to such other person as he may appoint for the purpose, access at all reasonable times to any records kept by the practitioner under these terms of service, and to furnish the Medical

Officer with any such records, or with any necessary information with regard to any entry therein, as he may require; and

(d) to answer any enquiries of the Medical Officer with regard to any prescription issued by the practitioner or to any statement made in any report furnished by him under these terms of service.

The expression "Medical Officer" in this paragraph means any medical officer appointed by the Minister for the district in which the practitioner carries on insurance practice.

Acceptance of Fees

9.—(1) Except as provided in Clause 7 hereof with regard to fees charged by way of deposit and in the scheme for the distribution of funds amongst insurance practitioners made under Part II. of this Schedule, a practitioner is not permitted to accept any fee or other remuneration in respect of treatment which he is required to give under these terms of service, or in respect of the supply to a patient of any drug or prescribed appliance, whether such drug or prescribed appliance is one which he is required by these terms of service to order or himself to supply.

(2) Except as provided in Clause 7 aforesaid a practitioner is not permitted to accept any fee or other remuneration in respect of any treatment given by him to a patient which is alleged to be beyond the competence of a general practitioner of ordinary professional competence and skill unless, within two days after the date on which the treatment is given, he has furnished the Committee, on a form to be supplied by them for the purpose, with such particulars relating to the service rendered as they may require.

Deputies, Assistants and Partners

10.—(1) Save as provided in this clause in the case of partners and assistants, all treatment shall be given by an insurance practitioner personally, except where he is prevented by urgency of other professional duties, temporary absence from home, or other reasonable cause: Provided that if the practitioner is unwilling to render any particular service or class of service within the competence of a general practitioner of ordinary professional competence and skill, he may make arrangements with another practitioner for the provision of such service by that practitioner as his deputy and on his behalf.

(2) A practitioner shall inform the Committee of the nature of any standing arrangements which he has made with any other practitioner or practitioners for securing the treatment of his patients in cases where he is unable, for any of the causes mentioned above, to give treatment personally, and shall not absent himself from his practice for more than one week without first informing the Committee of his proposed absence and of the person or persons responsible for conducting his insurance practice during such absence.

(3) *(a)* A practitioner shall not employ a permanent assistant to attend his insured patients without the previous consent of the Committee to the employment of such an assistant: Provided that the Committee shall not unreasonably withhold such consent, and shall in no case withhold consent without previous consultation with the Panel Committee, and that in case of disagreement between the Committee and the Panel Committee the practitioner shall be entitled to appeal to the Minister, whose decision shall be final.

(b) Before consenting to the employment by a practitioner of more than one assistant, the Committee shall obtain the approval of the Minister.

(c) The Committee may require that the name of any assistant so employed shall be placed on the medical list.

(4) A practitioner shall not without the previous consent of the Minister and of the Committee employ as a deputy or assistant any practitioner who is disqualified from being included in the medical list by reason of his name having been removed from the medical list of any Committee in Great Britain.

(5) A practitioner acting as deputy shall be entitled to treat patients at places other than those arranged by the practitioner for whom he is acting, due regard being had to the convenience of the patients.

(6) A deputy or assistant (other than a permanent assistant whose name is included in the medical list) shall, in addition to signing with his own name any medical certificate, prescription form, or other document required or authorised by these terms of service to be issued by a practitioner, insert therein the name of the practitioner for whom he is acting as deputy or assistant.

(7) A practitioner is responsible for all acts and omissions of any practitioner acting as his deputy or assistant.

(8) In the case of two or more insurance practitioners practising in partnership or as principal and assistant, treatment may at any time be given by a partner or assistant of the practitioner in whose list the patient is included, instead of by the practitioner in person, provided that reasonable steps are taken to secure continuity of treatment, but in the case of treatment given by an assistant the patient will be entitled to require the personal services of the principal, except where the latter is prevented from attending or is unwilling to attend for any of the reasons referred to in paragraph (1) of this clause.

For the purpose of this provision a practitioner will not be deemed to be a partner unless he is in the position of a principal in connection with the practice and is entitled to a share of the profits of the partnership which is not less than one-third of the share of any other partner.

Disputes, Appeals, Etc.

11. The terms of service relating to the following matters are contained in Parts V., VI. and VIII. of the Regulations respectively:—

(a) The investigation of questions arising between practitioners and their patients and other investigations to be made by the Medical Service Sub-Committee and the Joint Services Sub-Committee, and the action which may be taken by the Committee as a result of such investigations, including the recovery from the practitioner of any sum deducted from any Parliamentary Grants payable to the Committee.

(b) Appeals to the Minister from decisions of the Committee.

(c) The investigation of cases of alleged excessive prescribing.

(d) The determination of the question whether a particular service was within the competence of a general practitioner of ordinary professional competence and skill.

(e) Inquiries with regard to the continuance of a practitioner on the medical list.

(f) The obligation of a practitioner to provide treatment at a rate of remuneration not exceeding that payable in respect of an insured person for any disabled member of a society (as defined in Part VIII. of the Regulations) whom the Committee may under the powers conferred on them by that part of the Regulations require him to treat.

Power of Minister to Suspend the System

12. In the event of the Minister exercising any of the powers conferred on him by the proviso to sub-section (2) of Section 15 of the principal Act or by Section 11 of the Act of 1913, in respect of the area within which a practitioner is required to give treatment, the Committee may, if the Minister so requires, determine the practitioner's service on the medical list by giving him such notice as the Minister may require.

Issue of Notices to Practitioners

13. Any notice which a Committee is required or authorized by these terms of service to give to a practitioner shall be sufficiently given if it has been sent by post

or delivered to or at the address of which the practitioner has last notified the Committee as that of his place of residence.

Interpretation

14. Words of expression in these terms of service have the same meaning as in the National Health Insurance (Medical Benefit) Regulations, 1920 (herein referred to as the Regulations), and the Regulations shall, so far as they affect the rights and obligations of insurance practitioners, be deemed to form part of these terms of service.

APPENDIX B

TERMS OF SERVICE FOR PERSONS SUPPLYING DRUGS OR APPLIANCES

NOTE.—*The following provisions relate to persons, firms or bodies corporate entitled to carry on the business of a chemist or druggist under the provisions of the Pharmacy Act, 1868, as amended by the Poisons and Pharmacy Act, 1908 (in this Schedule referred to as "Chemists") who undertake the supply of both drugs and appliances. They must be applied to persons, firms or bodies corporate who are not so entitled or who undertake the supply of appliances only, with such modifications as the case may require.*

Admission to and Withdrawal from List: Method of Altering Terms of Service

1. Every person, other than one who is disqualified from undertaking service by reason of his name having been excluded or removed, after an inquiry, from any list of persons supplying drugs or appliances in Great Britain or in respect of whom an Inquiry under Part VII. of these Regulations is pending, who gives notice to the Committee in the form sent out in Part III. of this schedule with such modifications as the case may require, that he accepts service upon the terms for the time being in operation in the Committee's area, will have his name included in the Committee's list, but no person shall be entitled to undertake the dispensing of medicine unless he is entitled to carry on the business of a chemist or druggist under the provisions of the Pharmacy Act, 1868, as amended by the Poisons and Pharmacy Act, 1908, and undertakes that all medicines supplied by him to insured persons under the arrangements made by the Committee shall be dispensed either by or under the direct supervision of a registered pharmacist or by a person who for three years immediately prior to the 16th day of December, 1911, has acted as a dispenser to a practitioner or a public institution.

In this schedule "person" includes a firm or body corporate.

2. The Committee may, after consultation with the Pharmaceutical Committee, and subject to the approval of the Minister, alter the terms of service as from such date as the Minister may approve by giving notice of the proposed alterations to each person supplying drugs or appliances:

Provided that, except in the case of an alteration which results from the coming into operation of any new Regulations, Order, Order in Council, or Act of Parliament, or of an alteration made by the Minister in the Tariff, the alteration shall not come into operation within a period of three months from the date of the issue of the notice.

3.—(1) A chemist is entitled at any time to give notice to the Committee that he desires to withdraw his name from the list, and his name shall be removed therefrom at the expiration of three months from the date of such notice or of such shorter period as the Committee may agree:

Provided that—

(i) if such notice is given by the chemist within one month after the issue to him by the Committee of a notice informing him of a proposed alteration in the terms of the service, two months shall be substituted for three

months as the maximum period for which he may be required to continue to undertake the supply of drugs or appliances; and

(ii) if representations have been made to the Minister that the continuance of the chemist on the list would be prejudicial to the efficiency of the service, he is not entitled to withdraw his name from the list, except with the consent of the Minister, and subject to such conditions (if any) as the Minister may impose, during the period while an Inquiry under Part VII. of these Regulations, or action by the Minister as a result of such Inquiry is pending.

(2) The name of any person supplying drugs or appliances who dies during the year, or whose name is directed to be removed from the list by the Minister, will thereupon be removed from the list:

Provided that where upon the death of any person supplying drugs or appliances the business is carried on in accordance with the provisions of the Pharmacy Act, 1868, as amended by the Poisons and Pharmacy Act, 1908, by a person who is his executor or administrator or the trustee of his estate, within the meaning of Section 16 of the former Act, that person shall be deemed to be a person included in the list so long as the business is carried on by him in accordance with the provisions of those Acts.

Supply of Drugs and Appliances

4.—(1) The expression "appliances" in this Schedule means such medical and surgical appliances as may for the time being be prescribed by any Regulations as forming part of medical benefit.

(2) A chemist is required to supply with reasonable promptness to any person who presents an order for drugs or appliances on a prescription form provided by the Committee for the purpose and signed by any practitioner on the medical list of the Committee or his deputy or assistant, such drugs or appliances as are so ordered, and shall so far as practicable keep in stock for that purpose the drugs and appliances mentioned in the Drug Tariff for the time being in force.

(3) All drugs and appliances so supplied shall be of a grade or quality costing the chemist a price corresponding as nearly as may be to the price allowed for the drug or appliance by the Drug Tariff.

Place and Hours of Business

5.—(1) Drugs and appliances will be supplied at the place or places of business specified in the application made by the chemist for inclusion in the Committee's list, and the hours during which the place or places will be open for the supply of such drugs and appliances are those specified in the scheme to be made for that purpose under the Regulations.

(2) At each place of business at which a chemist supplies drugs or appliances he is required (i) to exhibit a notice to be provided by the Committee in the form prescribed in Part IV. of this Schedule, and (ii) to exhibit at times when the place of business is not open and in such a manner as to be visible at such times a notice to be provided by the Committee in the form prescribed in Part V. of this Schedule, indicating the days and hours on and at which the places of business of other persons supplying drugs or appliances in the immediate neighbourhood are open.

Provision of Containers

6. If a person, upon presenting an order for any drug or appliance for which a bottle or other vessel, the price of which is specified in the Tariff, is necessary, requests the chemist to supply such bottle or other vessel and deposits with him the price thereof as specified in the Drug Tariff, the chemist shall supply such bottle or other vessel and shall, upon the return of it in a clean condition pay back the sum so deposited.

Dispensing of Medicines

7. The dispensing of medicines shall be performed either by or under the direct supervision of a registered pharmacist or by a person who for three years immediately prior to the 16th December, 1911, has acted as a dispenser to a practitioner or a public institution.

Names and Qualifications of Dispensers

8. A chemist shall, if so required by the Committee, furnish to the Committee a statement of the names and qualifications, if any, of any persons employed by him in dispensing medicines for insured persons.

Drugs, &c., to be Supplied without Charge

9. All drugs and appliances shall be supplied to the person presenting such order as aforesaid free of charge to that person:

Provided nevertheless that the chemist shall sell to any one of the persons mentioned in Section 13 of the Sale of Food and Drugs Act, 1875, or to any person authorised by such person, at the price usually charged to private customers any drug or medicine prescribed or specified on the appropriate prescription form provided by the Committee for the use of insured persons and signed by an insurance practitioner.

Disputes and Inquiries

10. The terms of service relating to the following matters are contained in Parts V. and VII. respectively of the Regulations:—

(a) The investigation of complaints made by or on behalf of insured persons against persons supplying drugs or appliances and other investigations to be made by the Pharmaceutical Service Sub-Committee and the Joint Services Sub-Committee, and the action which may be taken by the committee as a result of such investigations, including the recovery from the person supplying drugs or appliances of any sum deducted from any Parliamentary Grants payable to the Committee;

(b) Appeals to the Minister from decisions of the Committee; and

(c) Inquiries with regard to the continuance of persons on the list of persons supplying drugs or appliances.

Power of Minister to Suspend the System

11. In the event of the Minister exercising any of the powers conferred on him by the proviso to sub-section (2) of Section 15 of the principal Act or by the proviso (i) to sub-section (5) of that section, or by Section 11 of the Act of 1913, in respect of the area of the Committee or any portion of that area, the Committee may, if the Minister so requires, determine the chemist's right to supply drugs and appliances under the foregoing arrangements by giving him such notice as the Minister may require.

Interpretation

12. Words of expression in these terms of service have the same meaning as in the National Health Insurance (Medical Benefit) Regulations, 1920 (herein referred to as the Regulations), and the Regulations shall, so far as they affect the rights and obligations of persons supplying drugs or appliances be deemed to form part of these terms of service.

METHOD OF PAYMENT (PHARMACY)

1. A chemist is required to furnish to the Committee or to such other person or body as they may direct, on dates to be appointed by the Minister, the forms upon which the orders for drugs and appliances supplied by him were given, together with a statement of accounts containing such particulars relating to the supply by him of drugs and appliances as the Committee, with the approval of the Minister, may from time to time require.

2.—(1) The Committee shall, if any person supplying drugs or appliances so requires, afford him reasonable facilities for examining all or any of the forms on which the drugs or appliances supplied by him were ordered, together with particulars of the amounts calculated to be payable in respect of such drugs and appliances, and if he takes objection thereto, the Committee will take such objection into consideration.

(2) The Committee shall, if so required by the Pharmaceutical Committee, afford that Committee similar facilities for examining such forms and particulars relating to all or any of the persons supplying drugs or appliances, and will take into consideration any objections made thereto by the Pharmaceutical Committee.

3. Payment will be made for drugs and appliances mentioned in the Tariff at the prices specified in the Tariff, and for drugs or for any variety of appliances not mentioned in the Tariff in the manner set forth therein. A fee for dispensing, calculated in the manner set forth in the Tariff, will also be paid.

4. If, at the request of the Pharmaceutical Committee, any sum has been allotted by the Committee to defray the administrative expenses of the Pharmaceutical Committee, a rateable proportion of such sum will be deducted from the amount payable to each person (other than a practitioner) supplying drugs or appliances.

5. In this part of the Schedule "Tariff" means the Drug Tariff for the time being in operation in the area of the Committee.

APPENDIX C

FORM OF APPLICATION FOR ADMISSION TO THE LIST OF PERSONS SUPPLYING DRUGS OR APPLIANCES

NATIONAL HEALTH INSURANCE

To the Insurance Committee for the County (or County Borough) of.....

.....

I (We).....of.....

hereby undertake to supply drugs and appliances upon the terms set out or referred to above, with such modifications, if any, as may from time to time be made therein in accordance with the procedure specified above, and apply to have my (our) name(s) included in the Committee's list of persons supplying drugs or appliances, My (our) place(s) of business for this purpose will be.....

Signed.....

Date.....

APPENDIX D

LIST OF APPLIANCES

Adhesive plaster.

Bandages, Rolled:

Calico.
Crepe.
Domette.
Elastic-web.
Flannel.
India-rubber.
Muslin.
Open-wove.
Plaster of Paris.

Catheters:

Gum-elastic.
Soft rubber.

Cotton Wools, Absorbent:

Boric.
Sal-Alembroth.
Unmedicated.

Gauzes:

Boric.
Carbolic.
Double cyanide.
Iodoform.
Picric.

Gauzes—*cont.*
Sal-Alembroth.
Sublimate.
Unmedicated.
Gauze and cotton wool tissue.
Ice bags:
Check sheeting.
India-rubber.
Lints:
Boric.
Sal-Alembroth.
Unmedicated.
Protectives:
Gutta percha tissue.
Jaconet.
Oiled cambric.
Oiled paper.
Oiled silk.
Splints.
Suspensory bandages:
Cotton.
Tows:
Carbolised.
Unmedicated.
Wood wool.

APPENDIX E

PROVISIONS AS TO PERSONS REQUIRED OR ALLOWED TO MAKE THEIR OWN ARRANGEMENTS FOR OBTAINING TREATMENT

1.—(1) The Committee may fix an income limit for the purpose of the administration of medical benefit, and may require insured persons whose incomes exceed that limit, in lieu of receiving medical benefit under the arrangements to be made by the Committee, to make their own arrangements for receiving treatment (including drugs and appliances): Provided that the Committee may exclude from this requirement any insured persons who ought in the opinion of the Committee to be excluded whether by reason of the occupation or method of remuneration of the class to which they belong or of their circumstances or residence or otherwise.

(2) The Committee shall inform the Minister of any income limit proposed to be fixed by the Committee under these Regulations, and shall, before fixing, varying, or abolishing an income limit, give public notice of their intention so to do and shall consult the Local Medical Committee and Panel and Pharmaceutical Committees, and shall consider representations made to them by any Society having members resident in the County.

(3) Any Society having members resident in the County, or any Panel Committee or Pharmaceutical Committee for the County may at any time, by notice in writing to the Committee, dispute the right of any insured person to receive medical benefit under the arrangements made by the Committee, on the ground that the income of that person exceeds the income limit and that he is not entitled to be excluded, or that, being an exempt person, his total income from all sources exceeds one hundred and sixty pounds a year.

(4) Upon receipt of any such notice the Committee may, if they think fit, give notice in writing to that person that, unless, within a period specified in the notice, he satisfies the Committee that his income does not exceed that limit or that he is entitled to be excluded, or that, being an exempt person, his total income from all sources does not exceed one hundred and sixty pounds a year, the Committee will require him to make his own arrangements; and if, within the said period, the insured person fails to satisfy the Committee as aforesaid, the Committee shall require him to make his own arrangements.

(5) Any decision of the Committee to fix, vary or abolish an income limit shall only take effect from the commencement of the succeeding calendar year.

(6) The Committee may allow any insured persons resident in the County, in lieu of receiving medical benefit under the arrangements made by the Committee, to make their own arrangements for receiving treatment.

(7) The period for which an insured person may be allowed to make his own arrangements shall be the period up to the end of the year in respect of which application is made or such longer period, as the Committee think fit.

(8) An insured person who is required to make his own arrangements for receiving treatment shall give notice to that effect to the Committee, and an insured person who desires permission to make his own arrangements shall apply to the Committee for permission in such manner as the Committee, with the approval of the Minister, may require.

2. If an insured person who is required or permitted to make his own arrangements for obtaining treatment removes temporarily from the County, he shall be deemed for the purposes of any contribution to be made to him towards the cost of such treatment, to have remained in the County. If he removes permanently he shall if required to make his own arrangements, give notice forthwith to that effect to the Committee for the County to which he has removed, and, if allowed to make his own arrangements, shall be entitled to apply to such Committee for further permission or to select another method of obtaining treatment, as he thinks fit. If the removal is permanent, his name shall be transferred from the Register of the Committee for the one County to that of the other as from the date on which the first Committee received notice from the second that he has given notice that he is required, or has applied for permission, to make his own arrangements.

3.—(1) For the purpose of enabling the Committee to make contributions towards the cost of treatment (including medicines and appliances) of persons required or allowed to make their own arrangements (in this Article referred to as "persons making their own arrangements"), there shall be credited to the Committee in respect of each year a sum equal to the amount available for treatment (including such sum as the Minister may estimate to represent the average cost of the supply of drugs and appliances to insured persons) of an insured person multiplied by the number of persons making their own arrangements in the area. The number of these persons shall be calculated by dividing by four the sum of the numbers of persons making their own arrangements at the commencement of each quarter. The sum so credited to the Committee shall be carried to a fund in their books to be called the Special Arrangements Fund.

(2) Where an insured person makes his own arrangements for obtaining treatment from a duly qualified practitioner, and the Committee are of opinion upon such evidence as they think sufficient that the arrangements are such as to secure treatment (including drugs and appliances) not inferior in nature, quality or extent to that provided under the arrangements made by the Committee there shall, subject as hereinafter provided, be paid out of the Special Arrangements Fund by way of contribution to the cost of the treatment and of drugs and appliances, amounts calculated as follows, namely:—

(a) the Minister shall determine what proportion of the sums credited to the Special Arrangements Fund shall be treated as available for defraying the cost of treatment, and what proportion shall be treated as available for defraying the cost of drugs and prescribed appliances.

(b) in the case of a person who has contracted for a fixed sum to obtain treatment for the year, or any part thereof, the sum so to be paid shall be a sum equal to the amount contracted to be paid by him or a sum equal to the aggregate amount in the Special Arrangements Fund which is or would, if no reduction were made in the fund by reason of the loss of any part of any Parliamentary grant, have been available for defraying the cost of treatment for that year or that part of the year divided by the number of persons making their own arrangements, whichever is the less, and the necessary amount shall be appropriated from the Special Arrangements Fund for that purpose: Provided that, where the person

who has so contracted to obtain treatment removes from the area within which that treatment is available during the period for which he has contracted to obtain treatment, the calculation shall be made as though the period for which he had so contracted were a period determining on the expiration of the quarter in which he removes, and the sum payable to him shall be reduced accordingly;

(c) in the case of a person who has not contracted for a fixed sum to obtain treatment for the year or any part thereof, or in the case of a person who has contracted for a fixed sum to obtain treatment for part of the year only, the sum, if any, expended by him in obtaining treatment for the year or for the remainder of the year, as the case may be, shall be deemed to be a sum calculated in accordance with a scale of fees fixed by the Committee, and payment shall be made accordingly, save that, where the aggregate amount expended by all such persons exceeds the amount in the Special Arrangements Fund available for defraying the cost of treatment (after deducting the amount appropriated under the last preceding paragraph), the amount contributed in the case of each such person shall be reduced proportionately;

(d) payment shall be made in respect of the cost of drugs and appliances out of the amount available in the Special Arrangements Fund for defraying the cost of drugs and appliances, and the method of calculating the amount payable shall be similar to that prescribed for payment in respect of the cost of treatment:

Provided that it shall be a condition of any payment that the drugs and appliances supplied to any person making his own arrangements with a practitioner shall be supplied otherwise than by or at the profit of the practitioner who is attending him, except where the circumstances of the person are such that the practitioner would, if he were attending that person under the arrangements made by the Committee be entitled under his agreement with the Committee to supply drugs and appliances to that person.

(3) Where an insured person contracts with a person, other than a duly qualified medical practitioner, to obtain treatment (whether including drugs and appliances or not) from him for a fixed sum for the year or any part thereof, the Committee may make such contribution towards the sum contracted to be paid, not exceeding in amount the maximum contribution payable in the case of a person who contracts with a duly qualified medical practitioner, as they think fit, but upon any representation being made by a Society that the treatment is not such as will adequately protect the funds of the Society, the Committee may either withhold the contribution or make such a deduction therefrom as they may in any case determine.

(4) Save as aforesaid, the Committee shall not make any contribution in the case of an insured person making his own arrangements who obtains treatment otherwise than from a duly qualified medical practitioner.

(5) Where the contract, if any, entered into between the person making his own arrangements and the person undertaking to give treatment does not require the latter person to comply with the conditions of any scheme for the distribution of a Parliamentary grant which must be complied with as a condition of payment of that grant, or where any treatment given to a person making his own arrangements does not comply with those conditions, and by reason thereof the sum payable to the Committee in respect of that grant is reduced, the contribution, if any, made by the Committee towards the cost of the treatment provided by that person shall be proportionately reduced.

(6) Any sum standing to the credit of the Special Arrangements Fund at the end of any year shall be carried forward to the credit of that fund for the succeeding year, so however that in the expenditure of the money to the credit of the Special

Arrangements Fund in that year regard shall so far as may be, be had to whether any sum so carried forward has arisen from moneys which under this Article were applicable to treatment or to the provision of drugs and appliances, and that the sum so carried forward shall be applicable accordingly.

APPENDIX F

FORMS OF CERTIFICATE

First Certificate of Incapacity for Work

To.....

I hereby certify that I have to-day examined you, and that in my opinion you are rendered incapable of work by reason of

*.....

.....

§You should come to see me again on.....day next.

Doctor's Signature.....

Date of Signing.....

Any other remarks by Doctor.....

*Here insert the name of the specific disease or bodily or mental disablement which renders the insured person incapable of work.

§To be filled up at Doctor's discretion, where not obligatory under Rules.

Intermediate Certificate

To.....

I hereby certify that I have to-day examined you, and that in my opinion you have remained incapable of work, up to and including to-day by reason of

*.....

§You should come to see me again on.....day next.

Doctor's Signature..... *Date of Signing*.....

Any other remarks by Doctor.....

*Here insert the name of the specific disease or bodily or mental disablement which renders the insured person incapable of work.

§To be filled up at Doctor's discretion, where not obligatory under Rules.

Final Certificate

To.....

I hereby certify that I have to-day examined you, and that in my opinion you have remained incapable of work, up to and including to-day by reason of

*.....

and are fit to resume work after to-day.

Doctor's Signature..... *Date of Signing*.....

Any other remarks by Doctor.....

*Here insert the name of the specific disease or bodily or mental disablement which renders the insured person incapable of work.

Special Intermediate Certificate

To.....

I hereby certify that I have to-day examined you, and that in my opinion you have remained incapable of work, up to and including to-day by reason of

*.....

I further certify that, judging from your present condition, your incapacity is of such a character that it will be unnecessary to see you for the purpose of treatment more frequently than once in.....† weeks, and that you will be incapable of work up to the end of †.....weeks from the date of this certificate.

I propose to issue certificates in this form at the intervals stated above so long as your condition does not require more frequent attendance.

Any other remarks by Doctor.....

Doctor's Signature..... *Date of Signing*.....

*Here insert the name of the specific disease or bodily or mental disablement which renders the insured person incapable of work.

†This number must not exceed four.

Special Final Certificate in Rural Areas

To.....

I hereby certify that I have to-day examined you, and that in my opinion you have remained incapable of work, up to and including to-day by reason of

*.....

and that in my opinion you will be fit to resume work on.....

.....

Doctor's Signature..... *Date of Signing*.....

Any other remarks by Doctor.....

*Here insert the name of the specific disease or bodily or mental disablement which renders the insured person incapable of work.

Notice to Approved Society
(See Rule 13)

I hereby declare that in the certificate of incapacity for work which I have to-day given to of (address), being Member No. of Society, Branch, I have stated the cause of the incapacity with less precision than my present knowledge of the insured person's condition makes possible, for good and sufficient reasons which I have this day communicated to the Medical Referee.

APPENDIX G

The following letter contributed to the *Scotsman*, June 12, 1920, emphasizes the existing amount of discontent with the new medical benefit regulations which have just gone into effect. It is not an uncommon occurrence for the doctor to pay for appliances, vaccines, serums, etc., himself, since no provision is made for such payment under the Acts.

THE IMPOSITIONS OF THE NATIONAL HEALTH INSURANCE ACT

June 8, 1920.

Sir,—(1) In pre-war days eighteenpence to two shillings was the sum allowed per head per annum to pay for drugs and appliances for insured persons. Even then this was insufficient. Drugs have risen in price as much as 800 per cent., but the allowance for medicines has not been increased! Hence it is that at the close of every quarter doctors have to pay the excess loss out of their own pockets. This may amount at times to as much as £40. The effect of this policy is to stereotype treatment to the fashion in vogue in 1912, and neglecting all later and more expensive remedies. This applies also to all vaccines, serums, and antitoxins, the applications of which have extended enormously during the war. These have to be paid out of the drug fund—in other words, by the doctor—as their cost far exceeds the paltry and inadequate allowance for drugs. Look at the result. If the doctor fails to give his patient of the very best for his ailment, he cheats him, and incurs the responsibility of failure or death; if he does give it, he cheats himself; so that in both ways the policy is immoral. Why is the doctor to worry himself over every case, saying to himself, My patient ought to have this medicine, but if I prescribe it, the checking bureau will be down on me at the end of the month, and at the end of the quarter I will be surcharged? This is not imaginary; I am surcharged without fail every quarter. Take two such common drugs as ergot and senega, both of which have risen in cost enormously. A case of hæmorrhage must have the one; a case of bronchitis must have the other. The doctor pays. And when, added to this injustice, one has a patient saying to you, "And now I want to pay for my medicine and get the best," implying that he has not been getting the best, while all the time you bitterly know that you will be called in question in the first place, and made to pay in the second, and that he has been getting the very best in the third!

Add to all this the fact that chemists now are very properly receiving 5d. for dispensing each prescription instead of 2d. as they had in the beginning, and that too comes off the 1s. 6d. or 2s., and the man in the street will understand that it is the doctor who is paying for his medicine, as the drug fund is wholly unable to bear this burden also. The doctor can either become unconscientious or pay it himself.

(2) *Free Vaccination.*—This has now been imposed on the profession without their permission being asked. Under our contract we undertook to attend the insured persons when ill. But those persons desiring vaccination come to us when well, and yet we have to attend them free of charge. Why we are not made to supply the vaccine lymph also is illogical from the Commissioners' point; they prefer to sponge on the Public Health Authorities for it.

(3) *Here is the latest.* Cards have been dealt out to all doctors under the Act. Every day they are to enter on those cards the number of visits paid to private patients, to insured patients, the distance in miles to private patients, and the distance in miles to insured patients. The first part of this is illegal. No doubt the Commissioners will state that it is for the purpose of estimating and paying for the mileage travelled by the doctor to his patients. If this is so, that is all right; but at present the mileage paid for is but a pittance of the cost in getting to the patient's house in the country. This mileage is to be estimated also in the towns; even when going from door to door, the distance is to be estimated in eighths of a mile! If a doctor is to visit patients on behalf of the Commissioners in the country, he ought to be delivered by them at the door of the patient, and be brought back. And if he is to spend his evenings in compiling useless returns when he ought to be resting or studying, he ought to be provided with a clerk. Every half-year burdens are laid upon us grievous to be borne. There is no remedy, as each succeeding amendment of the Act specifies that the Commissioners may make what alterations they choose. The new varieties of the Act bear no relation whatever to the original one, save that of the drug fund, which continues unaltered. There is now no cordial relationship between doctor and patient; it is now purely a business one, and behind it all is the ever-present bugbear of the Checking Bureau calling in question every prescription, until soon there may be little left in our pharmacopœia but salts and senna, or the sulphur and treacle of the well-named, "Do-the-Boys-Hall."—I am, &c.—VICTIM.

APPENDIX H

PAYMENT BY ATTENDANCE SYSTEM

On account of the practical importance of the system of payment by attendance, attention is directed to an address on "National Insurance: The Payment by Attendance System in Salford," by Dr. J. H. Taylor, *British Medical Journal Supplement*, January 28, 1920. This address, which includes an extended consideration of remuneration and the free choice of doctors, concludes with the statement that, "Of course it is not plain that the Manchester and Salford system brings in any greater remuneration to the panel doctors as a body, but it is claimed that the payment is more equitably distributed for work actually done than under the per capitation system. In addition, under the attendance system there is freedom of choice for both doctors and patients. The doctors have reached, at any rate, a greater degree of satisfaction than can possibly exist under the per capitation system with an unlimited system of responsibility for a very limited fee and only an approach towards freedom of choice as it is understood in private practice. At the same time it cannot fail to be a source of satisfaction to the insured to feel that they have at any time the same freedom of choice of doctors as if they were paying a private practitioner."

The address has been replied to in two letters by Dr. J. Charles, of Stanley, Durham, and Dr. E. H. Worth, London, in the *British Medical Journal Supplement*,

September 18, 1920. The details of the discussion are extremely interesting but cannot be enlarged upon further than to point out that according to Dr. Worth the average payment for a visit at the present time is about 1s. 6d. He gives expression to the view that, "The position in London for the medical benefit under the Act cannot be called satisfactory." And he presents statistics to show that out of about 5,800 doctors on the medical register only about 1,300 are on the panel. This would indicate that only about thirty per cent. of the physicians eligible for panel service were actually under agreement with the government, and he therefore concludes that "a new insurance scheme is necessary if the poor are to have the benefit of the best medical advice." To these observations he adds the extremely significant statement that "Thanks to the Insurance Act there is no unity in the profession; there are three groups, all pulling in different directions, without any present hope of ever coming together again. It is urgently necessary, therefore, that a Royal Commission should sit without delay and decide what new scheme should be put through."

APPENDIX I
THE FUTURE OF MEDICINE

In view of the frequent references which have been made to the treatise by Sir James Mackenzie, on the "Future of Medicine," attention may be directed to a memorandum on some of the medical aspects of the national health insurance act, drawn up by Sir James Mackenzie and the staff of the St. Andrews Institute for Clinical Research, issued as an appendix to the report of the inter-departmental committee appointed to consider and report upon the form of medical record to be prescribed under the terms of service of insurance practitioners contained in the Medical Benefit Regulations for 1920. An abstract of this report was printed in the *Lancet* of August 7, 1920. The report considers (1) Defects in medical knowledge, particularly as regards Diagnosis, especially in the early stages of disease; (2) The teaching of the general practitioner; (3) Central clinics; (4) Methods pursued at St. Andrews Institute for Clinical Research. The observations are summarized in the statement that:

1. The present phase of medical knowledge is defective, because the classification of disease is largely based upon pathological changes discovered after death, which bear little or no relation to the clinical manifestations of ill health and no relation to the early symptoms of disease which occur before structural changes can be recorded.

2. Advance in knowledge along the right lines can only be effected by making use of the opportunities of the panel doctor.

3. Encouragement must be given to the panel doctor to make use of his opportunities for improving medical knowledge by: *(a)* Encouraging him to keep brief records of his cases and of the symptoms presented on the lines indicated; of the effect of treatment upon them, and of the continuous history of his cases. *(b)* By issuing to him from time to time notes upon the mechanism and the significance of symptoms.

4. By improvements in medical education in affording some instruction on clinical medicine as studied and treated in general practice as apart from its study under hospital conditions.

5. In view of notes of cases kept by a practitioner as indicated, certificates of fitness or unfitness for work should be accepted apart from a definite diagnosis in the numerous cases in which a true diagnosis is not as yet attainable.

6. By the coordination of workers, clinical and laboratory, the progress of medicine can be favored, and the more skilful treatment of panel patients facilitated.

APPENDIX J

REMONSTRANCE OF PANEL DOCTORS

The following item is from the *Kent Messenger*, January 24, 1920, and included in the present discussion as a concrete illustration of the widespread dissatisfaction in the ranks of the medical profession with the operation of the panel system:

"Dr. Frank Coke, hon. medical secretary to the Kent Local Medical and Panel Committees, writes: 'It has come to my knowledge that a section of the press has already inserted articles, respecting a proposed organized resistance by medical men to the New Regulations for panel practice.

'I therefore enclose for your information a precise statement of the attitude of Kent medical men in this matter so that you may be in possession of the facts.'

"Kent Doctors in Revolt Against the Panel.

"We practitioners of Kent are placed by the Ministry of Health in an invidious position. Either we must accept a large number of New Regulations—many of which are plainly opposed to the interests of our patients, e.g., the forcible allotment of patients without their consent to particular doctors—and all of which do but perpetuate a discredited system, or we must forthwith resign all connection with what is generally known as panel practice. We are preparing to do the latter because we believe that the public regards us as the guardians of the public health, both by virtue of our training and also of a reputation for altruism which we are proud to enjoy and desire not to forfeit.

"However, we see very clearly that those who are morally or financially interested in the present system, e.g., politicians and the approved societies, may endeavour to misrepresent our actions, arguing that we are "striking" or that we are about to refuse to treat the sick, or that we are acting from political motives. It has therefore seemed best to put a clear statement before the public and this step is rendered even more advisable by the fact that our fight is very largely the fight of all free men against the burdens of bureaucracy. But first we would make it plain that in no circumstances will any sick person whatever find himself deprived of treatment because of our action.

"The chief points for which we contend are three in number and are as follows:—

"1.—That the efficiency of medical treatment shall be the first consideration of the Ministry of Health.

"2.—That no practitioner shall be deprived of his livelihood without a fair trial.

"3.—That the capital value of medical practices shall not be destroyed without compensation.

"Inefficiency of the Present System.

"At present the service is inefficient and this fact is generally recognised by the public. This inefficiency is not due to the careless work of greedy and dishonest practitioners but to the limitations imposed by the State.

"Thus the drugs and appliances supplied are extremely restricted, even such small items as eye-shades, throat brushes and inhalers being refused. In theory the doctor may order any drug that he would give to a private patient, in practice a doctor has been fined for using chloroform water as a flavouring—the cheapest flavouring known. Naturally the panel patient does not get the widest choice of drugs.

"Dental treatment, provision of spectacles and consultations are all wanting. Hospital treatment and home nursing are not provided. The war has shown how great is the value of "team work." So far from encouraging anything of this sort, the Ministry even refuses to recognise partnerships. It will be apparent that the sphere of usefulness remaining to the general practitioner is restricted to a few words and

a bottle of not too expensive medicine. The great objection to this is that the practitioner is required to treat all ailments, even the most dangerous, in circumstances which scarcely admit of proper treatment of the least. One cannot wonder that the system is discredited.

"It may be objected that all this would cost a lot of money, but medicine is not one of those things in which half-a-loaf is better than no bread. Half measures are dangerous or fatal. A further penny a week subscription should provide adequate drugs and consultations, together with some arrangement by which a panel patient leaving a voluntary hospital would at least bring his doctor some short account of what treatment he had had there or the diagnosis arrived at. Morover, the Ministry does propose to spend a great deal more money, but not on treatment, only on forms and reports. We may perhaps give an example. Should a patient suffer from incurable disease it is often kinder to put upon his certificate some term less precise than the circumstances would warrant. Formerly this was permitted, but now if a practitioner does this he is to notify the Medical Referee of the true nature of the patient's disease and also notify the patient's approved society that he has so notified the referee. So far as we know there is no specific form for this purpose, but there are many other new forms of about equal utility. It is on these that money is to be expended and not on treatment. Not only is the doctor not to be helped, but he is to be as much as possible hindered by a multitude of irritating and useless clerical duties. For the humane practice of medicine the Ministry has no use or regard.

"*The Right of Fair Trial.*

"This question involves a principle which extends far beyond the interests of a particular class.

"It is not only allowed by implication, but is specifically enacted in the New Regulations for panel practice that the Minister of Health may himself determine a complaint or refer it for a hearing without notifying the practitioner. It is not required that representations shall first have been made to the Minister by some other person interested. The actual inquiry is held by persons appointed by the Minister and the Minister himself gives judgment. One might imagine that dismissal from the service would be the extreme penalty but this is not so. The Minister may also fine the practitioner and also advertise his fault to his patient in such manner as the Minister thinks fit. Thus it is carefully laid down to admit of no doubt that a practitioner, without being heard in his own defence and without having a complaint made by any patient, may be utterly ruined by the mere fiat of the Minister of Health.

"It may be argued that these things would not in fact happen, but events in the past give us no certainty of this, and no argument of the sort can destroy the inherent impropriety of such enactments in a free country or make it easier for gentlemen to take service under a penal code evidently designed for the school-wrested from bureaucracy. Our fight is the Charta from a King, but one has yet to be wrested from bureaucrat. Our fight is the fight of all in this matter. We ask fair trial for any accused of misdemeanour; the powers given to the Minister of Health, not by Parliament but by Regulations, transcend those which should be allowed to any man.

"*Destruction of the Capital Value of Practices.*

"At present, if a practitioner dies or retires, his practice is often sold to a successor. The individual insured patient may of course then make fresh choice of any doctor he chooses, but there must always be a large number who by virtue of living near, etc., will go to his successor. Payment for these is continued to the successor without interruption, and it is this fact that creates the selling value of the practice. Mr. Lloyd George recognised this and when he introduced the Health Insurance

Act assured practitioners that there could not in consequence be any depreciation in the capital value of their practices. Now all of a sudden, the Ministry of Health, on which has fallen the old mantle of Mr. Lloyd George, announces that it never recognised any such thing as the capital value of practices. So far the doctor has a grievance, but it may be doubted whether the insured person has not a greater one for the Ministry has devised a unique method of achieving its end. The patients of the retiring doctor are, after a period of grace, to be allotted without their permission to such doctors as may be chosen by a central committee. Should they be sick they will go for treatment to a doctor chosen not by themselves, but by a body sitting, in the case of Kent, at Maidstone. Bad as this regulation is, it is not so bad for the insured person as one which the doctors have succeeded in getting removed—for the present. This one provided that the Ministry might start a doctor in practice in any place by the simple process of allotting to him a number of insured patients, the latter having no choice in the matter.

"We have as briefly as possible indicated some of the chief points in dispute with rampant bureaucracy. It is first and last, a fight to free from the numbing hold of red tape a science and an art that cannot but deteriorate in that atmosphere. As such it is as much the business of the public as our own, and for that reason we have made this statement."

APPENDIX K

In further illustration of the practical difficulties confronting panel practitioners to comply with the practically countless rules and regulations, the following statement from the *Lancet* of September 4, 1920, with particular reference to certificates under national health insurance, is included:

"*Certificates under the National Health Insurance Acts.*

"The Minister of Health, acting upon the report of the Inquiry Committee of the London Insurance Committee, has ordered that £50 be withheld from the Exchequer grant to the committee, to be recovered under Article 33 of the Regulations from a medical practitioner on the London panel. This heavy fine is inflicted in the following circumstances. The practitioner had given certificates in the usual form, stating that he had examined the patient on the dates named in them in respect of a patient whom he had not in fact visited for some time. He was aware that the patient had returned to his home from an infirmary in October, 1919, and gave the certificates up to January, 1920, when the patient died. It was not disputed that the patient was during this period incapable of work, or that in the practitioner's opinion he could never be otherwise. The penalty is a heavy one, but it must be remembered that it was in the power of the Minister to remove the practitioner from the panel, and that to furnish a certificate at variance with the facts is not only a breach of the regulations, but is wholly unjustifiable in principle. A medical certificate of incapacity which states that a patient has been seen by the certifier is evidence from a trusted witness that he is alive and entitled to sickness benefit. A man may be certainly and inevitably dying, but the fact of his being beyond question alive is important, and if fraud is rare and difficult to perpetrate it is not impossible or inconceivable. One of the allegations made against our admittedly faulty system of death registration is that it does not effectively prevent burial without the presentation of the prescribed certificate, and that a certificate obtained for one person can thus be kept and used for another whose death has not been registered. Such fraud may be neither frequent nor easy, but in so far as it can occur, it would render possible the payment of sickness benefit in respect of a person who was dead. That no fraud should have been perpetrated or dreamt of by anyone in a particular case does not detract from the importance of certificates relating to sickness or death being absolutely accurate and trustworthy."

APPENDIX L

THE MEDICO-POLITICAL UNION

The present status of the controversy between the medical profession and the government is set forth with admirable clearness in a publication entitled "The Situation and the Panel Practitioner," issued by the Panel Medico-Political Union, 47 Fleet Street, London, E. C. This publication should be read by all who desire a full understanding of the controversy, however much made light of by those who find it to their pecuniary advantage to defend the present system. It is said, for illustration, that,

"Within the whole medical faculty there is no more sharply dividing line than that which separates the panel from the non-panel man. *The one is a Government servant—the other is not.*" It is therefore argued that:

1. The insurance act has created a class of medical men who, by their office as government servants, are totally distinct in function and in interest from the rest of the profession.

2. It is necessary for these men themselves, and for the government which employs them, that they should be organized in a separate body so that they and the government may deal with one another in a manner which is definite, emphatic, and unconfused.

3. The British Medical Association exists for and is the outcome of the whole medical faculty. It belongs to the panel man as fully as to any other member of the profession.

4. It is to the interest of the panel man to be also a member of the association:
   (a) Because his private and individual interests as a general practitioner are —or should be—represented within that body. It is his own fault if they are not.
   (b) Because, as a member of that body, he can best resist the present opposition to the success of his Union.
   (c) Because within the association he can express and find adjustment for the inter-action of his dual capacities—an inter-action continually in evidence between private and panel work.
   (d) Because as a panel man he will find in the British Medical Association established forces and avenues of influence which will be of service to his panel union.

The alternative offered is a reorganization of the British medical profession through the Panel Medico-Political Union on the basic principle of a trade union, because, it is said, "an organized refusal to work is a safe instrument only in the hands of Trade Unionism, the Panel Medico-Political Union has been registered under this head." It is said further, that "Nothing can be more certain, therefore, than the fact that the refusal to work on the part of the united medical profession must obtain this demand or wreck the Insurance Act." As a solution it is suggested that "It should never be forgotten that State medicine, with whole-time medical officers, however unsatisfactory it may be to the profession and to the public, is certainly much more economical from the financial standpoint, and does not present a tithe of the complexities from the point of view of administration."

It is of interest in this connection that according to a press dispatch dated September 29, 1920, Vienna, "Four thousand doctors of Vienna who have been treating patients under the auspices of sick benefit associations [in other words, compulsory health insurance] have gone on a strike and they are refusing to make visits except for the regular fee of their private practice."

APPENDIX M

THE GLOUCESTERSHIRE PLAN FOR EXTENDING MEDICAL SERVICES

There has recently been made public an extremely interesting plan for the extension of medical services, promoted by the Gloucestershire County Council. This plan was adopted on April 24, 1920, though based upon scheme of out-stations establishing connection with general hospitals, inaugurated under date of April 16, 1918. On February 6, 1919, the principal scheme was approved by the Gloucester Branch Council of the British Medical Association, and formally adopted at a mass meeting of the local medical profession in May, 1919, and finally by the county council under date of July 7, 1919. In September a grant of £7,000 was made towards the capital expenditure made by the Joint War Committee of the British Red Cross Society and the Order of St. John. The scheme was formally approved by the Ministry of Health under date of April 15, 1920. The plan has been explained in a pamphlet issued by the Glouscester County Council; price, 1s. Copies are obtainable upon application to Dr. J. Middleton Martin, the county medical officer of health. This experiment will be watched with considerable interest, for if successful it no doubt is assured of nation-wide adoption. The plan, in brief, would seem to be a systematic development of local clinics or out-stations in connection with local hospitals and other institutions. The use of the out-stations are primarily for examinations and out-patient treatment in connection therewith for *(a)* venereal diseases, *(b)* tuberculosis, *(c)* ex-service men, *(d)* school children, and *(e)* maternity and child welfare. It also seems to be in contemplation to use out-stations for dental clinics.

The medical and nursing staffs of the out-stations are intended to consist of *(a)* an executive medical officer; *(b)* medical officers for treatment, (1) a regular staff consisting of local practitioners appointed as medical officers of the out-stations by the board of management, (2) a consultant staff consisting of *(i)* visiting staffs of the general hospitals, *(ii)* the medical officer (clinical) of the county council; *(c)* nursing, including (1) district nurses, (2) masseur or masseuses, (3) V. D. orderlies and nurses.

The expenses of the scheme are provided for through *(a)* the county council; *(b)* the hospitals. The board of management consists of twenty-five representatives of official, medical and allied interests. There is not, however, a single representative of the local insurance committee or approved societies.

Provision is made for future expansion, it being said that, "The machinery thus created readily lends itself to expansion for the provision of other medical services, *e.g.*, extended treatment of insured persons; general treatment of persons such as can be given at out-patient departments of hospitals, and schemes for the care of sick and infirm when the Poor Law system is revised." It is intended, in time, to provide bacteriological and pathological assistance in the examination of specimens, etc., coordination of all specialist services and institutions, research, etc. The estimated capital cost of opening the out-stations is placed at £14,000, and the estimated annual expenditures are £15,000. Of the maintenance expenditure, the Ministry of Pensions will pay the whole cost for ex-service men, and the Ministry of Health will make grants of seventy-five per cent. for venereal diseases and fifty per cent. for other services. This applies to an area of 786,000 acres, containing 75,000 houses, with a population of 328,000, and fifty-five health centers, hospitals, and out-stations. The average area for a center is given as 14,300 acres, or 22.4 square miles. The radius of a circle is about two and a half miles, including approximately 1,370 houses, and a population of about 6,000.